BALTIMORE. MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

49 DIRECTOR: /

Item

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31. DATE FILED (Month, Day, Year)

151995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) El-Habz Asdallah Union Memorial

32. REGISTRAR'S SIGNATURE

After

FUNERAL within 72 h HOSPITAL

80

PHYSICIAN: The law requires that the death certificate be executed within an hours after death. Page 6 may be retained by the hospital or attending physician.
this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hydrith state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items# G-film 720 per F.H 19.a.22. 2/15/95 P.C STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Lessie Rose Cragway February 4.23 AH M 1995 4. SOCIAL SECURITY NUMBER 5. SEY 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day, Year) 3-23-1948 DAYS HOURS MIN 1 M 2 X F 215-52-2547 46 YRS. Md 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Union Memorial Hopsital DIRECTOR Baltimore City RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md Balto 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3929 Kenyon Avenue 21213 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuben, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 X Married BY Specify: 3 Widowed 4 Divorced **Black** COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY Medical Records Elementery/Secondary (0-12) College (1-4 or 5 +) Union Memorial 8 8 2vrs 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ Carmella Minnis Luther L. Jones, BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAJLING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Keith Grayway Craqway 3929 Kenyon Avenue Balto, Md 21213 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stats DATE King Memorial Park Randallstown, Md 4 ☐ Donation 5 ☐ Other (Specify) 21695 21. SIGNATURE OF FUNERAL SERVICE LICEN 22. NAME AND ADDRESS OF FACILITY
March F/H West
4300 Wabah Ave Balto, Md 21215 erome 23. PART | Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, ahock, or haart fallura. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final disease or condition resulting in death) Onset and Daath Adult Respiratory Distress 1st day DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): 2 days CERTIFICATION Sequentially list conditions. if any, leading to immediate cause. Enter UNDERLYING Left post obstructive cifelectaris 10 days CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Hyasthenia Gravis 2 years PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a, WAS AN AUTOPSY PERFORMED None 1 X YES 2 NO OF DEATH? 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 10 27. MANNER OF DEATH 28b. TIME OF 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 X Natural 5 Pending 1 YES 2 NO ΒY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 28 4 Homicide 29a. CERTIFIER (Check only 1 🔣 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
be filed within 72
IMPORTANT: II 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) & Hah to ► Feb/12/1995 AT 343 89 4 6 2



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Horrs 201 E. Univ DKW Balt

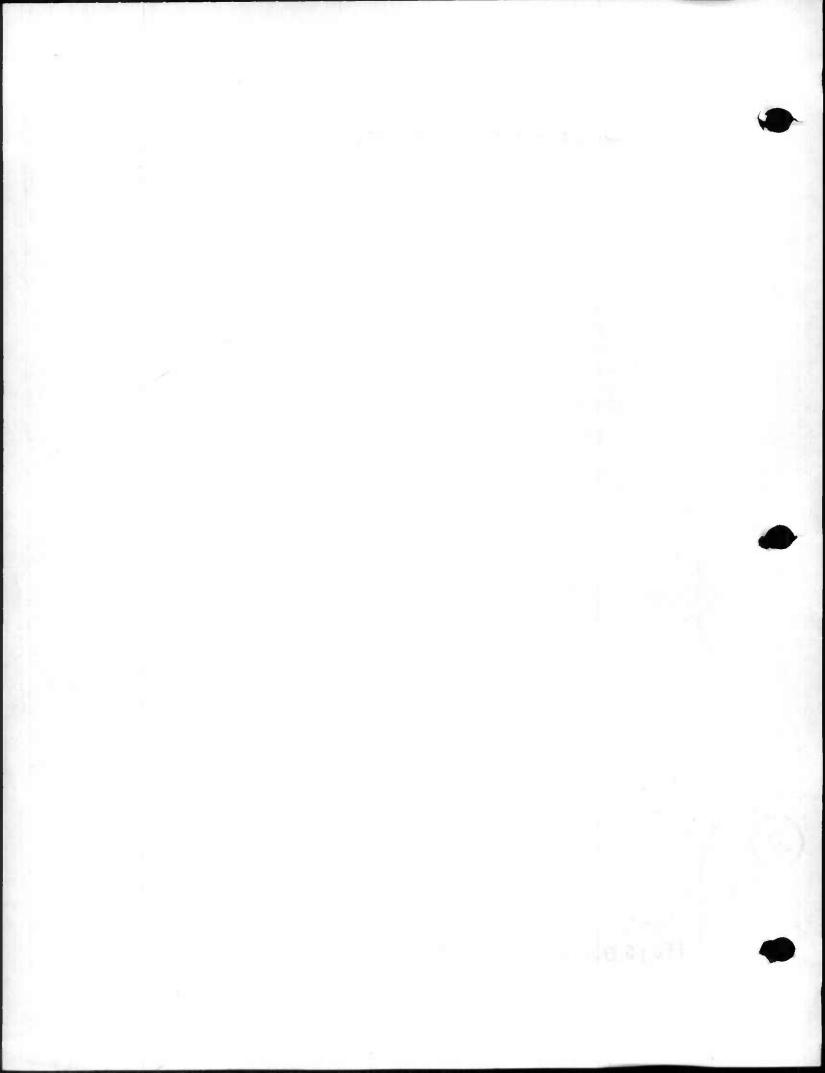
w be retained by the hospital or attending physician	page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		be notified at once.	
TO THE INSTITUTIONS PHYSICIAN: The law requires that the death certificate be executed within your after death, Page 6 may be retained by the hospital or attending physician	R. After th	be lifed writin it. A cours are death with the State Lebt. or health and Mentla Hyglene prior to burkal, cremation, or removal.	IMPORIANT: II ITELII 26 15 MATRED, OT ILEITI 23 SNOWS ANY INJUTY, OF OTHER TRAMMETIC EVENT, THE MEDICAL EXAMINER MUST be notified at once.	

MELITO A

FEB 1 5 1995

TORRES, MO 32. REGISTRAR'S SIGNATURE DAWNES RONDON

		FOR 1 - STATE REGISTRAR	STATE OF MA	RYLAND /	DEPAR ERTIFI	TMENT OF CATE OF	HEALTH AND I	MENTAL HYGIEI			
		1. DECEDENT'S NAME (First, Middle, Last)	Y ISABE		Coop			2. DATE OF DEATH MONTH	DAY	YEAR 995	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 218-10-5726	1 M 2 X F	AGE (In yrs. las		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (12-15-19		8. BIRTHE Country	PLACE (State or Foreign
9	200	9a. FACILITY NAME (If not Institution, give alreet and number) EAST POINT NURSING HOME RESIDENCE OF DECEMENT									
	מעומ	MARYLAND BALT	IMORE COU	NTY	10c. CITY	TOWN OR LOCA					10d. INSIDE CITY LIMITS? 1 YES 2 NO
	AC JA	412 N. PATTERSON				10	21231			S.A	HAT COUNTRY?
NO 20	5	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR	YES 2 X		If yes, a	CENDENT OF HISPAN pecify, Cuban, Maxicar S 2 NO Specify		es or No—	14. RACE Black, Specify	American Indian, White, etc.
DI ETEN	1	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	Ompleted) College (1-4 or 5 +)	(Gilife.	ive kind of we Do NOT use		ION lost of working	16b. KIND OF BU			DEACK
ed at once.	11th Grade HOUSEKEEPER CITY HOSPITAL										
TO T		Jereline McLaurin	1					timore, M			1213
r must		20a. METHOD OF DISPOSITION 1 X Buriel 2 Cremation 3 Remov 4 Ooneifon 5 Other (Specify)		cemetery, crei	matory or oth	tar Con	notory	2/17 Ba1	timor	e, M	aryland
examine		21. SIGNATURE OF FUNERAL SERVICE LICE	-	-	0111-0	Will 1	am C. Bro W. North	wn Commur Avenue	nity F	/H	
or other traumatic event, the medical examiner must be notitied at once.		23. PART I. Enter the diseases, or co shock, or heart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in dasth) s.	at Only one cause	on esch line					Iratory srr	est,	Approximata interval Between Onset and Death
CATION		Sequentially list conditions, b.		AS A CONSECULAR AS A CONSECULA		sis	lisease				
or other trau		If any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST		AS A CONSEC							
5 0		PART II. Other algnificant conditions	contributing to de	oth but not re	eswiting in	the underlyin	g cause given in P	ert i. 24s. WAS AN	AUTOPSY	24h W	PERE AUTOPSY FINDINGS
MEDIC		Congestive	Hen	7	Faul	lav		PERFOI	RMED?	0	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
item 23			HOSPITAL:	(Outrotlant 2		отнея:	LACE OF DEATH (Chec				
1 Inpetiant 2 ER/Outpetient 3 DOA 4 Privaling Home 5 Realdence 8 Other (Specify) 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 2 Accident 3 Suicide 6 Could not be 28b. DATE OF INJURY 28b. TIME OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 YES 2 NO 28c. PLACE OF INJURY At home, farm, street, factory, office 28l. LOCATION (Street and Number or Rural Routh Policy Injury 28b. Time OF INJURY 28b. Time											
28 円	1	3 Suicide 6 Could not be detarmined	26a. PLACE OF IN building, etc.	JURY — At hor (Specify)	ne, farm, str	eel, factory, offic		281. LOCATION (Street : City or Town, State)	and Number o	or Rural Rou	ite Number,
MPORTANT: If Item 2 D BE COMPLET		29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA ONE) 2 MEDICAL EXAMINER:	N: To the best of my On the beels of exemi	knowladge, dea nation and/or in	th occurred	at the time, date	end place, and due to	o the cause(a) end mar me, data and place, an	oner sa state	d. Cause(a) e	nd menner as stated.
TO BE C		29b. SIGNATURE AND TITLE OF CHILITIES	th,	n.	160	۵.0	29c. LICENSE NUME	50	29d. DATE	SIGNEO (N	fonth, Day, Year)
		30. NAME AND ADDRESS OF PERSON WHO CO	TORRES	F DEATH (ITEM	27) (Type, P	41 S.	ELLWO	Of AUE,	BA	LTO,	195 MD 21224



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3. TIME OF DEATH

BEG NO

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last 2. DATE OF DEATH MONTH MLIN A SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Morith, Day, Year 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 - M 2 0 F -16permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 5203 NUTH AVE DIRECTOR TIMORE 10c. CITY, TOWN OR LOCATION MARYLAND BALTIMORE CITY 10e. STREET AND NUMBER FUNERAL 101 ZIP CODE 203 21206 signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit Health and Mental Hygiene prior to burial, cremation, or removal. NUTA ours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No If yes, specify Cuben, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 1 Never Married 2 Merried ВУ 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) (Specify only high College (1-4 or 5+) ntary/Secondery (0-12) CLERK 12 17. FATHER'S NAME (First, Middle, Last) ANDREG WLING ATHERINE notified at BE 19e. INFORMANT'S NAME (Type/Print) 0 6. e 20e_METHOD OF DISPOSITION
1 A Buriel 2 Cremetion 3 Removal from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY VANS 800 Pair 8 or other traumatic event, the medical 23. PANT I, Enter the diseases, or complications that caused the deeth, shock, or heart failure. Liet only one cause on each line. Do not enter the mode of dying, auch as cerdiac or respiratory arrest, IMMEDIATE CAUSE (Final cardiac failure diseese or condition resulting in deeth) acute DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE DE) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in deeth) LAST item 23 shows any injury, PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL this certificate has been with the State Dept. of PHYSICIAN: OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA Home 5 Residence 8 □ Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? is marked, 1 Natural DIRECTOR: After the hours after death w M 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Sulcide COMPLETED 8 Could not be 28 4 Nomicide to the Funeral Directs of fied within 72 hours a limportant: If item 2 29e. CERTIFIER 1 S. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date end place, end due to the cause(e) and manner ee stated, HOSPITAL 2 MEDICAL EXAMINER: On the beste of examination end/or investigation, in my opinion, death occured at the time, date and piece, and due to the cause(e) and menner se stated 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE THE THE P

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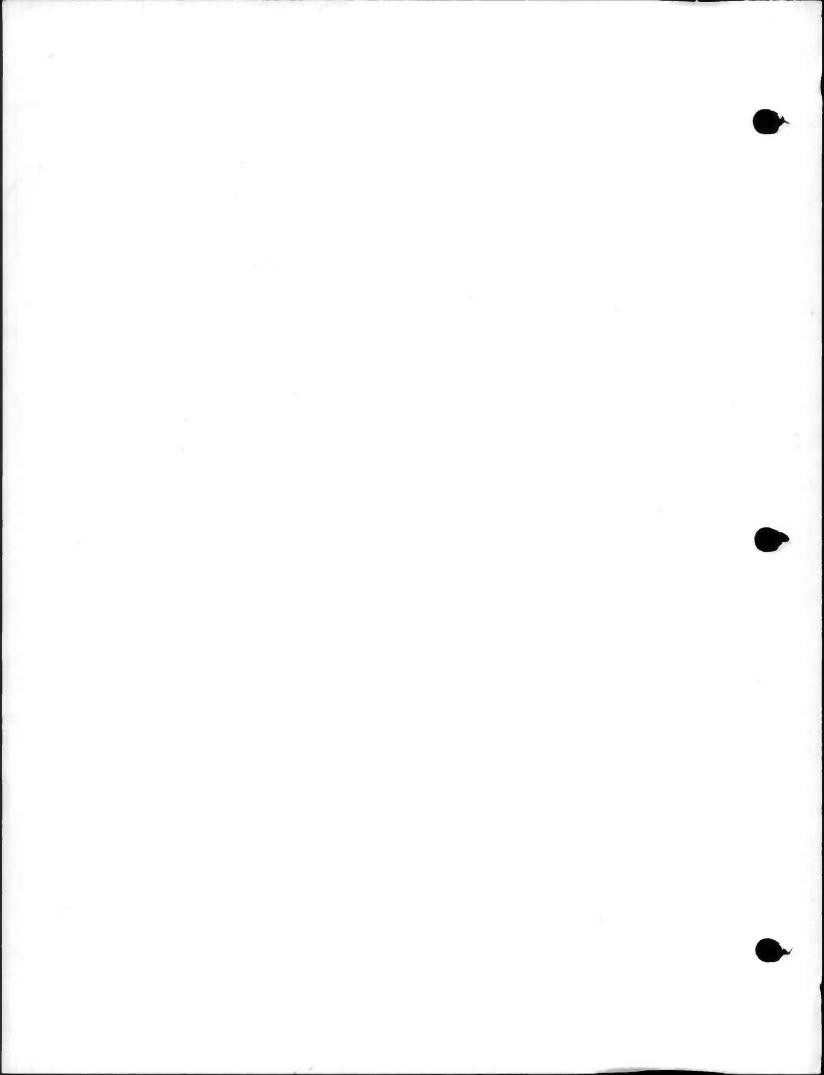
la 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

5601

32. REGISTRAR'S SIGNATURE

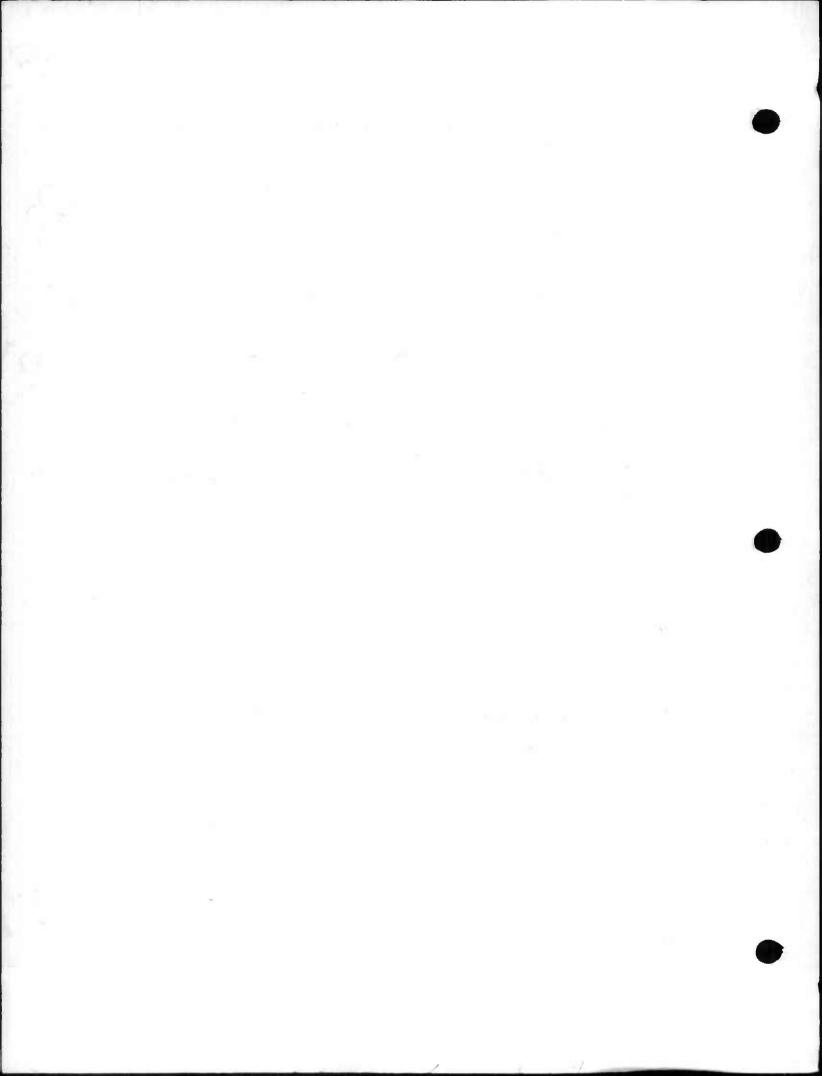
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

> 8. BIRTNPLACE (State or Foreign Country) RALT 9c. COUNTY OF DEATN 10d. INSIDE CITY YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? WHITE 16b. KIND OF BUSINESS/INDUSTRY U.S. GOV. MD. 21212-3715 Approximata Intervel Between **Onset and Death** notantemore 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24n. WAS AN AUTOPSY PERFORMED? 1 TES TO NO OF DEATH? 1 TYES 2 NO 28d. DEŞCRIBE NOW INJURY OCCURED 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) D16587 DHMH-18 Rev 1/89



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	equires that th
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		1 - STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
		1. OECEDENT'S NAME (Prot. Middle, Lyst)	n Cell	ste	Davi 3	2. D/ WC	ATE OF OEATH DAY	5 95	3. TIME OF DEATH	
Pir	Ti li	4. SOCIAL SECURITY NUMBER 212-76-7881	1 M 2 X	n yra. last birthday) 35 YRS.	MONTHS DAYS HO	URS MIN. (M	TE OF BIRTH Conth, Day, Year) 5-03-59	8. BIRTI Count	HPLACE (State or Foreign ny) MARYLAND	
1, 2, 3 should	TOR	9a. FACILITY NAME (If not institution, give sti UNIVERSITY HOSPITESIDENCE OF DECEDENT			BALTIMO	ORE CITY		9c. COUNTY OF D	EATH	
if. Pages 1	DIRECTOR	10a. STATE 10b. COUNTY MARYLAND			SALTIMORE C	CITY			10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
physician. burial-transit permit. Pages	FUNERAL	3705 Brice Run Ro			101. ZIP	.133-3818		U.S.A		
	BY FU	11. MARITAL STATUS 1 Mever Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 V NO	If yes, specify	ENT OF NISPANIC ORI Cuben, Mexican, Puer NO Specify:	GIN? (Specify Yes o to Ricen, etc.)	r No 14. RACI Blac Spec	E — American Indian, k, Whita, atc. #y: BLACK	
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the hospital e detached fo t once.		12th grade 17. FATHER'S NAME (First, Middle, Lest)	4 years	Admin	ı	MOTNER'S NAME (Fir		rmame)	-	
retained by the hospital of should be detached for notified at once.	TO BE	Woodrow Johnson 190. INFORMANT'S NAME (Type/Print)			G ADDRESS (Street and N		lumber, City or Town,			
e 6 may be ector, page must be		Emma C. Johnson 20a. METNOD OF DISPOSITION V.Y Burlal 2 Cremation 3 Remo	val from Stata 20b.	PLACE AND DATE	N. Pavson of Disposition (Name of other piece) The Park Ceme		ATE 20c. LOCA	TION City or To		
death. Page tuneral direction	91	21. SIGNATURE OF FUNERAL SERVICE LICE		LOUGOI	William	OORESS OF FACILITY	Communi		Marytand	
hours at ed in by or reme		23. PART I. Enter the diseases, or concendent of the concentration of th	omplicatione that caused list only one cause on each of the cause of	ich ilne.	South of the mode of the south of the southo	3	endisc or reepira	tory arrest,	Approximate Interval Between Onset and Dasth	
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v requires that the been signed by to of Heafth and shows any li	MEDICAL	PART II. Other significent conditions AIDS AML in 166 DID TOBACCO USE C	He partis	s C			24s. WAS AN AL PERFORM 1 YES 2	ED?	WERE AUTOPSY FINDINGS ANALIABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
PHYSICIAN: The law this certificate has by with the State Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:			OF DEATH (Check on				
ATTENDING PHYSICIAN: The ECTOR: After this certificate his after death with the State D 28 Is marked, or item	ву Рн	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		M 1 YES	2 NO	DEŞCRIBE HOW INJ			
OR ATTENOING OIRECTOR: After hours after death item 28 is ma	LETED	3 Suicide 8 Could not ba 4 Homicide detarmined	28a. PLACE OF INJURY building, atc. (Spec	my)			OCATION (Street and lity or Town, State)		Route Number,	
E AZ =	COMPLET	(Check only 1 MEDICAL EXAMINER	IAN: To the best of my knowl						a) and manner as stated.	
TO THE HOSPI TO THE FUNER be filed within	TO BE	29b. SIGNATURE AND TITLE OF CERRIFIER 30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF SE	OTH (ITEM 27) (7/s)	1000	PO684	16	► a	5/95	
/	7)	Minh Vo	AZ HETUSTRANDSKOM	Un	LAIR	Hospit	al E	Ballyin	ON MA	
	-	FEB 1 5 1995 34	V ETHTOGRAPH ACTINGO							



beath. Page 6 may be retained by the hospital or attending physician. functal director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should **BALTIMORE, MARYLAND 21215-0020**

DIVISION OF VITAL RECORDS, P.O. BOX 68760

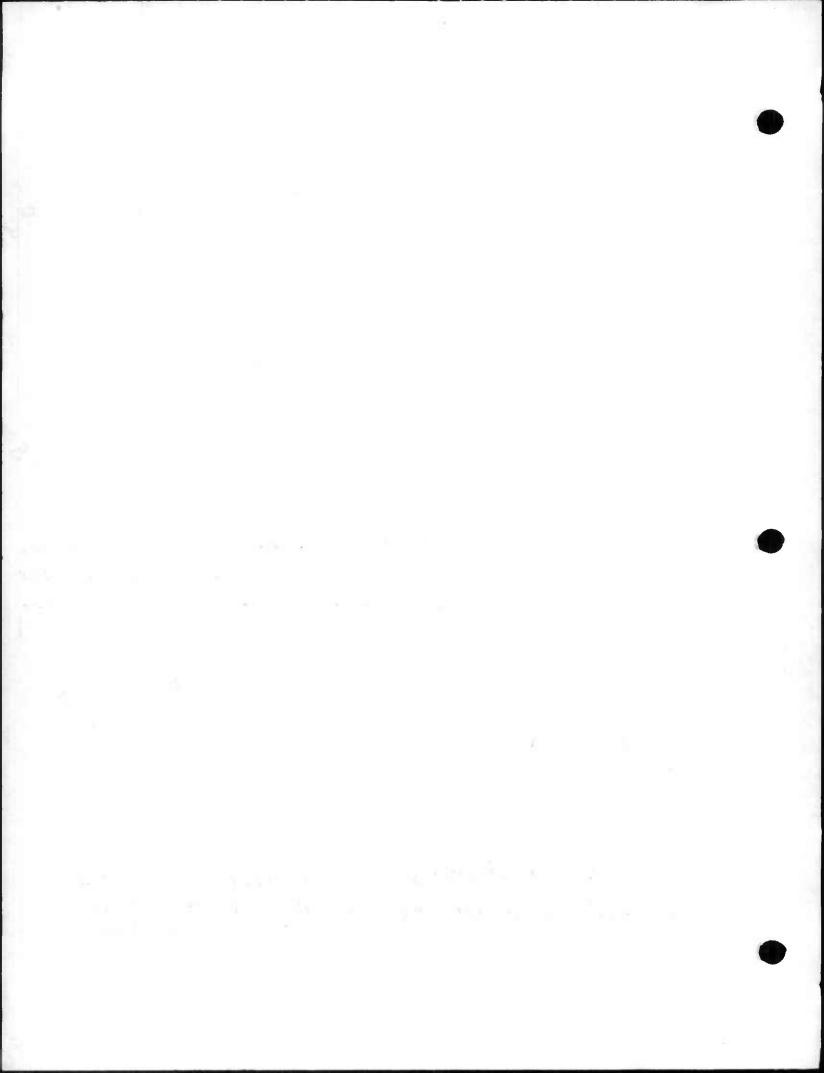
TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the damth certificials be essound within the hours after death. Page 6 may be retained by the hospital programmer of the second of the programmer.	TO THE FURENAL URECIDIT After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached the filed within 72 hours after obath with the State Dept. of Health and Mental Hydrene prior to burial, certified in removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR 1 • STATE REGISTRAR	STATE OF MAI	RYLAND /	DEPAR	TMENT	T OF H	IEALTH DEAT	AND N					
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1	WALTER			DA	BROW	SKI			MONTH O2	D	3	YEAR Q 5	0555 M
	220 02 0000						IF UNDER	24 HRS. MIN.	7. DATE OF 1 (Month, De 05 20	HRTH y, Ybar)		1 -	LACE (State or Foreign
	9a. FACILITY NAME (If not institution, give street	and number)			9b. CITY	, TOWN C	OR LOCATIO	ON OF DE		20	9c. COU	ITY OF DE	
OR	THE JOHNS HOPKIN	S HOSPITA	L			BALT	'IMOR	E CI	TY				
S	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		19c. CITY, TOWN OR LOCATION										
DIRECTOR	Md. Balti	more	Colgate									10d. INSIDE CITY LIMITS?	
N.	10e. STREET AND NUMBER	-11010			ryat	-	ZIP CODE				10a CITI		1 YES 2/ NO
ER/	7737 Eastdale	Road					212				USA		IAI COUNTRY?
FUNERAL	11. MARITAL STATUS 1	2. WAS DECEDENT EV	ER IN U.S. ARI	MED	13.	WAS DEC			IC ORIGIN? (S	pecify Yes			- American Indian, White, atc.
BY F	1 Never Married 2 Married 3 🔀 Widowed 4 Divorced	FORCES? 1 [OR DATES	0		If yes, sp	ecify Cuber 2 NO	n, Mexicar Specify:	n, Puerto Ricar	i, etc.)		Black, Specify	
			1								h	White	<u> </u>
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7	Elementary/Secondary (0-12)	College (1-4 or 5+)		hine					Wes	tern	Elec	ctric	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				L			IER'S NAI	ME (First, Middl	e Mairien	Sumame)		
BE C	John Dabrowski						_	ance		o, maroun	our ranney		
TO B	19a. INFORMANT'S NAME (Type/Print)		19b	. MAILING	ADDRESS	S (Street a	nd Number	or Rural R	loute Number, (lity or Town	n, State, Zip	Code)	
F	Joanne Mazurek		8	04 S	. Anı	n St	reet	Balt	timore	.Md.	2123	31	
	20a. METHOD OF DISPOSITION 1	of from State	20b.PLACEA	ND DATE	F DISPOS	ITION (Na			DATE	20c. LO	CATION —	City or Tow	n, Steta
	4 Donation 5 Other (Specify) Oak Lawn Cemetery 2-16+95 Eastwood, Md.												
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE A. I.	con.				D ADDRES		ler &	Con	Tno		
	Charles N	June			62	224	Easte	ern Z	AVA B	21+0	MA		
	23. PART I. Enter the diseases, or con shock, or heart failure. Lis	nplications that ca	used the dea	ath. Do r	ot enter	the mo	de of dyl	ng, such	as cardiac	or respi	ratory arr	est,	Approximate
	IMMEDIATE CAUSE (Final	11.		0	1:	7	1	_	,				Onset and Death
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CERTIFICATION	Sequentially list conditions,	DUE TO (OR	AS A SONSEO	UENCE OF	A	لما	90	/	read	4	de	seo	e cyro
E	If any, leading to immediate cause. Enter UNDERLYING	C	ler	. "	co	S	In	on	~				Edwar
Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OR	AS A CONSEQ	UENCE OF	9:		4						C .
EH	resulting in death) LAST												
	PART II. Other significant conditions of	contributing to dea	th but not re	esulting	n the un	derlying	cause o	Iven in I	Part I, 24e	WAS AN	AUTOPSY	24b. V	VERE AUTOPSY FINDINGS
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밁									_ ''	YES 2	No.	- 1 - 0	OF DEATH?
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PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	_	26. PLACE									_	
š		Inpotient 2 ER	Outpatient 3	DOA	4 Nun		s ⊡ Rec	sidence (8 Other (Sp	ecity)			
H	27. MANNER OF DEATH 28s. DATE OF INJURY 28s. TIME OF 28s. INJURY AT 28s. DESCRIBE HOW INJURY OCCURED INJURY OF INJURY OF INJURY OCCURED												
B	2 Accident Investigation M 1 YES 2 NO												
	3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJUSTY — At home, farm, street, factory, office 28st. LOCATION (Street and Number or Rural Route Number building, etc. (Specify)						ute Number					
5													
COMPLETED	(Check only onl)												
8	2 MEDICAL EXAMINER:	on the books of examin	setion end/or in	rvestigatio	n, in my o	pinion, d	eath occurs	ed at the t	ilme, date and	place, and	f due to the	canae(s) e	and manner as stated.
H	Will adoute the title of certifier	elen	ws				33 Arice	NSE NUM	DER O		29d, DATE	SIGNED IN	AC Mary
0	The state of the s		-	,				17	17 6	-	P 2	1 5/	45

DEATH (ITEM 27) (7500, Point)

600 N. WOLFE ST HARVE

DATE FILED (MINITO, Day, Near) FEB 1 5 1995



completely filled in by the rial, cremation, or removal.

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Hygiene prior to burial,

been signed by the attending physician it. of Health and Mental Hygiene prior to

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RECO	 The law requires that the death certificate be exect.
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OF VI	HYSICIAN:
DIVISION OF VITAL RECORDS, P.O.	IR ATTENDING PHYSICIAN: 1
\leq	OR
_	HOSPITAL OF

FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN JOHN ADAM DOELFEL 1995 FEBRUARY 12, 8:07 au 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. lest birthday) IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR 7. DATE OF BIRTH DAYS 218-22-0447 1 X M 2 F 94 HOURS YRS May 23, 1900 Maryland 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10b. COUNT 10d. INSIDE CITY N/A Maryland Baltimore 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3214 Chesley Avenue 21234 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 1 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No --14. RACE — American Indian, Black, White, etc. 2 X NO If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 X NO Specify: 1 Never Married 2 X Merried IF YES, GIVE WAR OR DATES Specify: BY 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life_Do NOT use retired.)

LEAN 6. 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Sp Elementary/Secondary (0-12) College (1-4 or 5+) 3rd. Crain Operator Civil Service once. 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Heineman 17. FATHER'S NAME (First, Middle, Last) John Michael Doelfel 76 Elizabeth Regina Heimeman BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Dorothy M. Beacham (Dghtr) 8211 Edwill Avenue, Baltimore, Md. 21237 ě 20a, METHOD OF DISPOSITION
1 A Burlel 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, Slate must Oak Lawn Cemetery 4 Donation 5 Other (Specify) 2/16/95 Baltimore, Maryland examiner 21 SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral home 3331 Brehms Lane, Baltimore, Md. 21213 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert fallure. Liet only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition MYOCARDIAL
DUE TO (OR AS A CONSEQUENCE OF): INFARCT resulting in death) traumatic event, NEUMONIA CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL ENALFARLIRE shows any 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h Hem HOSPITAL: OTHER: 1 YES 2 NO etient 2 - ER/Oulpatient 3 - DOA 4 Nursing Nome 5 Residence S Other (Specify) marked, or 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, lerm, atreet, fectory, office building, etc. (Specify) 3 Suicide DIRECTOR: A 60 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 8 Could not be 4 Homicide 200 determined COMPLET Item 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as atteted. (Check only one) TO THE HOSPITAL
TO THE FUNERAL I
DE FIED WITHIN 72 H
IMPORTANT: If II 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ce TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 9 RESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FEB 1 5 1995 32 MEGISTRAR'S SIGNATURED

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR ERTIF					MENTA	L HYGIEN REG. NO.	E		
0.00	1. DECEDENT'S NAME (First, Middle, Last) WALTE	RE), E	BA	UG	Н			2. DATE MONT			YEAR 5	3. TIME OF OEATH
	4. SOCIAL SECURITY NUMBER 213-12-6403	5. SEX 6. AGE (In yrs. last birthday) if under 1 YEAR if UNDER 24 Hrs. 7. DATE OF BIRTN (Month, Day, Year)								Country	PLACE (State or Foreign) Vland		
N.	9a. FACILITY NAME (If not institution, give street and number) Alice Manor Nursing Home						n LOCATI			20 19		NTY OF DE	4
5	RESIDENCE OF DECEDENT							2.1					
Maryland							time						10d. INSIDE CITY LIMITS? XX YES 2 \(\text{NO} \) NO
VERA	100. STREET AND NUMBER Alice 2095 Rockrose	Avenue	:		ome	101	. ZIP CODI		211		10g. CIT		HAT COUNTRY?
BY	11. MARITAL STATUS 1 Never Merried 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	TEVER IN U.S. AR YES 2 1	MED		II yea, sp	ENDENT Cooling	n, Maxica	n, Puarto	N? (Specify Yaa Rican, atc.)	or No-	14. RACE Black, Specify	- American Indian, Whita, atc. White
15. OECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) O 17. FATNER'S NAME (First, Middle, Lest) Tohan Calvin Ebaugh 18. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter 18. MOTHER'S NAME (First, Middle, Lest) Marrie I amada Krobs							ting Co.						
BE COM	17. FATNER'S NAME (First, Middle, Last) John Cal	vin Eba	augh							Middle, Maiden Nada K		s	•
TO B	19a. INFORMANT'S NAME (Type/Print) Barbara Mauerh	an	4	426	Cly	des	nd Number	or Rural F	Poute Num	ber, City or Town	to.	, MD	21211
	20a, METHOD OF DISPOSITION 1 & Burlet 2 Cremation 3 Ramoval from State 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Carmetion (Name of Carmetion) State Carmetery, crematory or either place) New Cathedral Cem. 2/15 Baltimore, Maryla												
	21. SIGNATURE OF FUNERAL SERVICE LIC	ensee Cay	penter							unera			MD 21211
	23. PART I. Enter the diseases, or cahock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	ist only one cau	t caused the delege on each line. UM MICH	,		the mo	da of dyl	ng, such	h as car	diac or reapl	ratory arr	rest,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		(OR AS A CONSEC										
PHYSICIAN: MEDICAL C	PART II. Other significant conditions Thostale	contributing to	death but not re	esulting I	n the un	derlylng) cauae ç	Ivan in	Part I.	24a, WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
AN:	DID TOBACCO USE CONTR	IBUTE TO CA					UNC	ERTAIN	<u>ا ۵</u>				
/SICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Input lant 2 ER/Output lant 3 DOA 1 Nursing Nome 5 Residence 6 Other (Specily)												
ВУ РНУ													
	3 Suicide 8 Could not be 4 Homicide detarmined	28e. PLACE O building,	F INJURY — At hor atc. (Specify)	ne, farm, s	treet, facto	ory, office			281. LOC City	ATION (Street a or Town, State)	nd Number	or Rural Ro	ute Number,
COMPLETED	29a. CERTIFIER Check only 2 MEDICAL EXAMINER												and manner se stated
8	29b. SIGNATURE AND TITLE OF CERTIFIER	The same	Dis of	0	, ,			NSE NUM	BER	prince prince; and			Month, Day, Year)
유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALL	E OF PEAK PER	1 0 T	24.0		P	0	16		- 4	1477	1

who completed cause of Death Otem 27) (Type, Print)
and Diamond 3730 Falls Road Baltimore,

Richard Diamond

32. REGISTRAR'S SIGNATURE

31 ONTE FILED (Month, Day, Year, FEB 1 5 1995

MD 21211

death. Page 6 may be retained by the hospital or attending physician. -TIMORE, MARYLAND 21215-0020

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

m 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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31. DATE FILED (MONTH), Day, Year).
FEB 1 5 1995

U/d/ing M.D.

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DIMISION OF VITAL RECORDS, P.O. BOX 68/60	WE	as b	lept.	23
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	TO THE HISPORTOR ATTENDAND PHISIONAL: The law requires that the death certificate be executed within 24 hours after dea	TO THE PLACERAL MECTOR AND THE THIS CREATING TO BE DOOD SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE FUN	be first with 22 hours are death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT IT THE ZE IS MARKED, OF ITEM 23 Shows any injury, or other traumatic event, the medical exa

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	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND /	DEPARTMI RTIFICA	ENT OF	HEALTH AND		YGIEN EG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last) Ward Juniv	r Eddins	ś				2. DATE OF O	EATH DA	13	YEAR 1995	3. TIME OF GEATH 7:56 A M
	4. SOCIAL SECURITY NUMBER 417-32-6875	1 3€ M 2 □ F	M 2 F 66 YRS. MONTHS DAYS HOURS							Country	LACE (State or Foreign
TOR	90. FACILITY NAME (If not institution, give to Sinai Hospit			9b.		n or location of d	EATH		9c. COU	NTY OF DE	ATH
DIREC	10a. STATE 10b. COUNT Maryland	Y		10с. СІТУ, ТО		lore					10d. INSIDE CITY LIMITS? 1 X YES 2 NO
FUNERAL DIRECTOR	10e. STREET AND NUMBER 10f. ZIP CODE					10f. ZIP COOE 21215			10g. CIT		HAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Merried 2 X Married 3 Widowed 4 Divorced	12. WAS DECEOENT EVER FORCES? 1 YES	2 7	MED IO	If yes	DECENOENT OF HISPA , specify Cuban, Maxic YES 2 NO Speci	an, Puerto Rican,		or No	14. RACE	- American Indian, White, etc.
COMPLETED	15. OECEDENT'S EOU (Specify only highest grade Elementary/Secondary (0-12) 6th	(Gr	CEDENT'S USUA ve kind of work d Do NOT use retir	lone during red.)	most of working	Con	cre		. Pi	pes	
6th Iruck Driver Products Compan											
								. 21244			
	20a. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Rem 1 Donation Other (Specify)	N	b. PLACE A metery, crer fead	ND OATE OF DIS	POSITION Pace)	(Name of 2/18 (emorial	Park	20c. LOC	re1	City or Tow	n, Stata ryland
	21, SIGNATURE OF FUNERAL SERVICE LIN	O. Ke	it	+	LEF 460	OY O. D'O IJBER'	YETT & PY HEI	GHT	SAV	ENU	
	ahock, or heart silure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	· Metastatic) /	lune		mode of dying, suc	ch as cerdiec o	or reapli	ratory an	reat,	Approximate Interval Between Onset and Death & Manyles
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST								years		
0	PART II. Other significant condition	is contributing to deeth i	but not re	esuiting in the	e underl	/ing ceuse given in		WAS AN A	MED?	1 6	WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE DE DEATH?
PHYSICIAN: MEDICAL	DID TOBACCO USE CONT. 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE C		TH YES			N 🗆			- 1	YES 2 NO
HYSIC	EXAMINER? 1 YES 2 YNO 27. MANNER OF DEATH	HOSPITAL: 1 Stinpation 2 ER/Out 28s. DATE OF INJURY		DOA 4 D	HER: Nursing I	Iome 5 Residence	6 Other (Spe		JURY OC	CURED	
ED BY	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide detarmined	(Month, Day, Year) 28a. PLACE OF INJURY building, atc. (Spe	Y — At hon			WORK? YES 2 NO	281. LOCATION City or Tow		nd Number	or Rural Ro	ute Number,
OMPLET	29a. CERTIFIER (Check only 1 CERTIFYING PHYSI	ICIAN: To the best of my know									and manner as stated

29c. LICENSE NUMBER

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29d. DATE SIGNED (Month, Day, Year)

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DIVISION OF VITAL RECORDS, P.O. BOX 13146,	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate he executed within
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	1 - FOR STATE OF M	MARYLAND / DEPARTME CERTIFICATION				YGIENE EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF D		YEAR 3. T	IME OF DEATH		
	4. SOCIAL SECURITY NUMBER 8. SEX	X			2		5	6 Per		
	225-20-9234 10 12 85	68 YRS. MONTH	S DAYS	OURS MIN.	7. DATE OF B (Month, Day	6-26	Country)	E (State or Foreign		
TOR	90. FACILITY NAME (If not institution, give street and number) Canden Yakas Nursi	10	Ba L-	LOCATION OF DE	O ·	9c. COUNT	Y OF DEATH			
DIRECTOR	10a. STATE 10b. COUNTY	10c. CITY, TOW	N OR LOCATIO	N			- 100	INSIDE CITY LIMITS? VES 2 \(\square\) NO		
	10a. STREET AND NUMBER			IP CODE	2	10g. CITIZE	N OF WHAT			
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Merried 1F YES, GIVE V 3 Wildowed 4 Divorced	YES 2 NO		DENT OF HISPAN ty Cuben, Mexica NO Specifi	n, Puerto Rican		Specify:			
2	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working (if the Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY									
COMPL	17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 19. MOTHER'S NAME (First, Middle, Maiden Surname)									
TO BE	196. INFORMANT'S NAME (Type Print) Neredith Fax	19b. MAILING ADDR	ESS (Street and	Number or Rural	Route Number, C	ity or Town, State, Zip Co		Marko		
	20s. METHOD OF DISPOSITION 1 Description Surface Su	20b. PLACE OF DISPOSITION other place)	on (emet	ery	20c. LOCATION — CI	-	State		
	22. NAME AND ADDRESS OF FACILITY J									
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING		vasto				51,	Approximate interval Betwae Onset and Deat		
MEDICAL	PART II. Other significant conditions contributing to	daeth but not resulting in the	undarlying (cause given in		WAS AN AUTOPSY PERFORMED?	AWAI CON OF I	LE AUTOPSY FINDINGS LABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 postlent 2	□ ER/Outpatient 3 □ DOA 4 □	ER:	CE OF OEATN (CA						
	27. MANNER OF DEATH 280. DATE OF (Month, L	INJURY 28b. TIME OF	28c. INJUR	FY AT (?		BE HOW INJURY OCCU	REO			
red BY	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					N (Street and Number of wn, State)	Rural Route	Number,		
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the bast of a							I manner as stated.		
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	Win	1	PO. LICENSE NUI	MBER	29d. OATE	SIGNED (Mor	oth, Day, Year)		
TO B	Housend			D18	484	12	110	1145		
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAU H. TAVASSOLI.	E My	345	5 Wil	1612/	VS AUE 1 212	7 41	300		
	FEB 1 5 1995 July Davids	AR'S SIGNATURE ON NONCOLL								

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use as the burial-transit after death. Page 6 may be retained by the hospital or attending physician. 10g funeral director, page 5 should be detached ysician and completely filled in by the prior to burial, cremation, or removal. the attending physician Mental Hygiene prior to n signed by the Health and N has been s Dept. of H this certificate h OR ATTENDING PHYSICIAN: After I DIRECTOR: after hours THE HOSPITAL O THE FUNERAL D filed within 72 ho TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: II

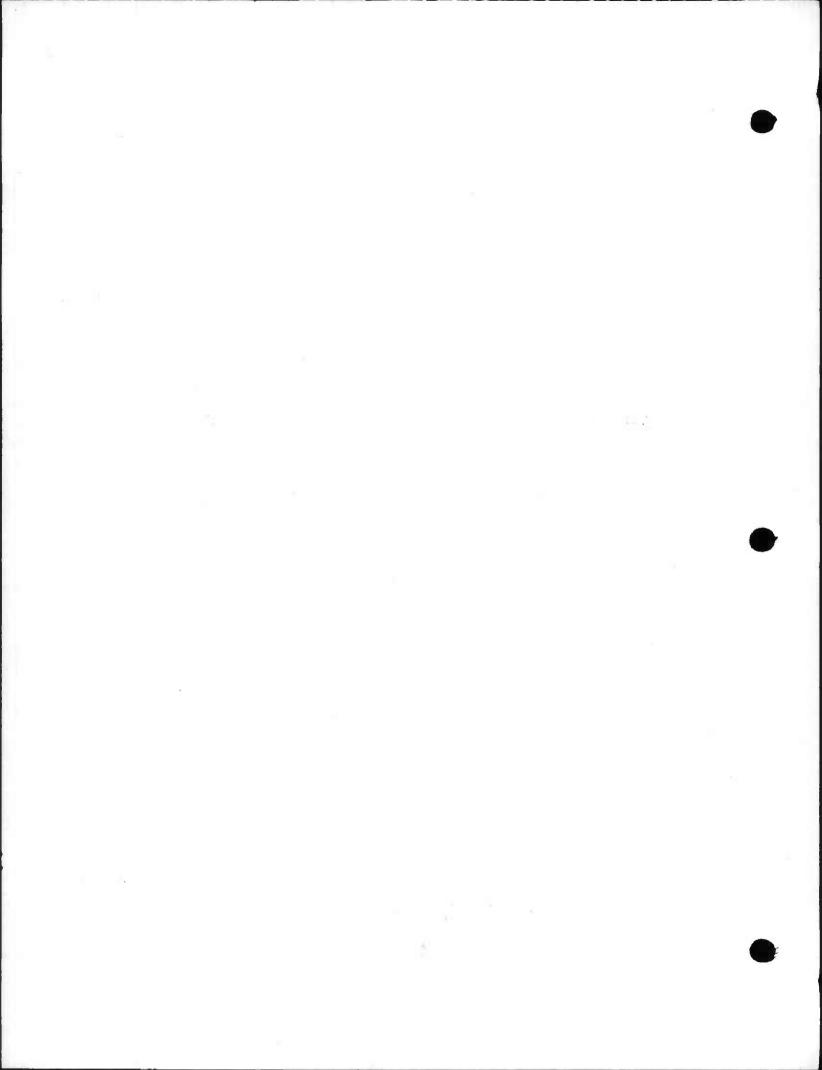
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH She AM nestine 1:55 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 73835-66 20 1 M 2 DF permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MARYLAND GENERAL HOSPITAL DIRECTOR more RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Jeg 1 X YES 2 NO FUNERAL 10e, STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 33 31228 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-44. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Rid 1 YES 2 X NO Specify: 1 Never Married 2 X Merried IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced BLACK COMPLETED 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KINO OF BUSINESS/INOUSTRY (Specify only high Elementary/Secondary (0-12) 4 SCHOOL TEACHER **SCHOOL** once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ JOHN C.WILDY HELEN CAMPBELL notified 190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 RT.1 BOX 5301WEEMS1VIRGINIA 2257L ONEAL FISHER be 20e. METHOD OF DISPOSITION
1X Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must SHARON "CEMETERY 1-18 LANCASTER -VA. 4 ☐ Donation 5 ☐ Other (Specify) the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY CENTRAL VA. FUNERAL SERVICE P.O.BOX 26528-RICHMOND-VA.23261-6528 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, Approximate ahock, or heart failure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Respiratory Failure unknown event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Lung Metastasis traumatic CERTIFICATION Sequentially list conditions. OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate CAUSE Enter UNDERLYING Breast Cancer 3 years CAUSE (Disease or Injury other QUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST 70 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS shows any COMPLETION OF CAUSE 1 TYES XXNO OF DEATH? 1 | YES 2 | NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) 1 TES 2 NO OTHER: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) -27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural
2 Acciden 5 Pending 1 YES 2 NO B Accident 28e. PLACE OF INJURY — At home, ferm, atreet, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) .00 ETED 8 Could not be 4 Homicide 28 determined Hem 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end manner es atated. COMPL 2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) BE 89226 Georgia an n.g. P. 13

Georgia cu, M.D. c/o Maryland General Hospital

32. REGISTRAR'S SIGNATURE Studior Rand

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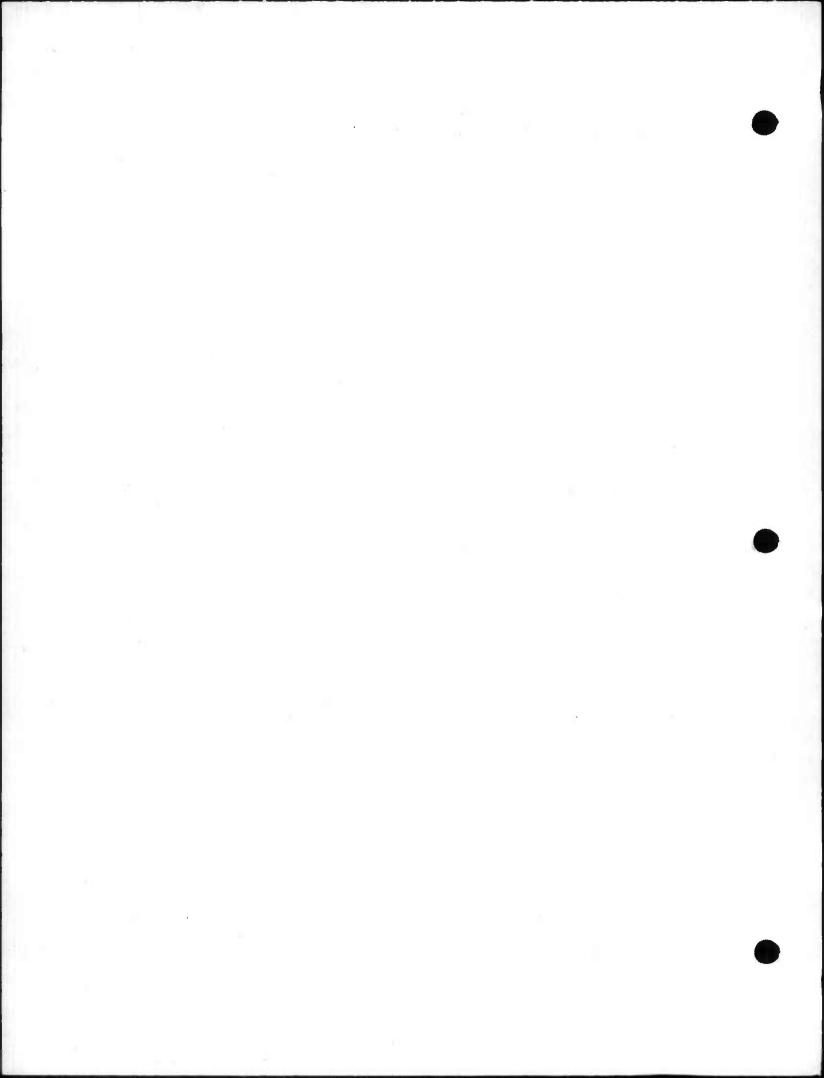
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la		F UNDER 1 YE	AR IF UN	DER 24 HRS.	7. DATE (OF BIRTH		8. BIRTHPL	ACE (State or Foreign
9		214-74-0582	1 🗆 M 2 💢 F	93	YRS.	ONTHE DA	WS HOUR	S MIN.		n 12,	1900	Bon Bon	dwell SC
should	_	9a. FACILITY NAME (If not institution, give s	treet and number)		9	b. CITY, TO	WN OR LOC	TION OF DE				TY OF DEAT	гн
2, 3	стов	1029 Wedgewoo	d Rd.			Ва	altin	nore				Md.	
Pages 1.	REC	10a. STATE 10b. COUNTY	1		10c. CITY,	TOWN OR L	OCATION					10	id. INSIDE CITY
ř. Pa	줍	Md.				Balt	timor	e.				1)	LIMITS? YES 2 \(\) NO
the burial-transit permit.	AL.	10e. STREET AND NUMBER					10f. ZIP C	DDE			10g. CITIZ	EN OF WHA	T COUNTRY?
ransit	FUNER	1029 Wedgewoo						2122	9			U.S.	Α.
burial-tra	3	11. MARITAL STATUS 1 Never Married 2 Married		YES 2			DECENDEN a, specify Cu			? (Specify Yes lican, etc.)	or No-	14. RACE — Black, W	American Indian, Vhite, etc.
the b	BY	3 X Widowed 4 Divorced	IF YES, GIVE W	WAR OR DATES		1 🗆	YES 2	O Specify	y:			Specify:	Black
detached for use as the once.		15. DECEDENT'S EDUC (Specify only highest grade		16a. Di	ECEDENT'S US	SUAL OCCU	PATION	dring	16b.	KIND OF BUS	SINESS/IND	JSTRY	
10 To 10		Elementary/Secondary (0-12)	College (1-4 or 5	+)	the kind of wor Do NOT use i	retired.)	y most or wo	rung					
ached	COMPL	10		H	lousev	vife				<u> </u>	usew	ife	
be detached for use at once.		17. FATHER'S NAME (First, Middle, Last)					18. M			fiddle, Maiden		1	
5 should 1	8	Thomas Bond 19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING A	DORESS (St	met and Num			ne Ne		Codel	
5 should	임	Arrie Long		"									. 21229
page st pe		20a. METHOD OF DISPOSITION 1 Surial 2 ☐ Cremation 3 💆 Rame	numl from State		AND DATEOF	DISPOSITIO			DATE			ity or Town,	
firector, p		4 Donation 5 Other (Specify)		- Cemetery, co	on Ba	aptis				eb18	,199	5 Bo	ndwellSC.
tuneral direction		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	1	1	Ca.	eltor	RESS OF FA	DOUG	ılass	Fun	eral	Service
he fur Al.		Carton	C. h	loud	an	170) 1 Mc	Cull	oh S	St. B	alto	. Md	. 21217
ompressey filled in by the funeral director, page 5 should be ind, cremation, or removal. c event, the medical examiner must be notified at		23. PART i. Enter the diseases, or of ahock, or heart failure.	complications that List only one cau	t caused the de	eath. Do not	enter tha	mode of	dying, auc	h aa card	lac or respi	ratory arre	est,	Approximata Interval Between
y filled tion. or the m		IMMEDIATE CAUSE (Final disease or condition	CHAN (YOU CO.	0	-	1.							Onset and Death
ompletely al, cremati event, t		resulting in death)	DUE 70	(OR AS A CONSE	MUN	1715							
comprisal, c	-		DOE 10	(OH AS A CONSE	COENCE OF J:								
sician and con rior to burial, traumatic en	ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSE	QUENCE OF):								
hysician prior	CA	cause. Enter UNDERLYING CAUSE (Disease or Injury	с,										
nding phy Hygiene p	Ħ	that initiated eventa DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST											
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ed by the att th and Menta any Injury,	AL	PART il. Other significant condition	s contributing to	death but not	resulting in	the under	lying ceus	e given in	Part i.	24s. WAS AN			ERE AUTOPSY FINDINGS AILABLE PRIOR TO
signed by the Health and ws any in	EDICAL		0510	coar	+n1	11	7		_	1 _ YES 2	2	CC	OMPLETION OF CAUSE F DEATH?
of He		DID TOBACCO USE	CONTRIBUTE	S C CALL	105 (SEATH	VEC I	7 NO				- 1	YES 2 NO
has been of P	AN	25. WAS CASE REFERRED TO MEDICAL	CITICIDOTE	TO CAU	01 1		6. PLACE OI			- 1			
State C	SICIAN: M	EXAMINER?	HOSPITAL:	ER/Outpatient		THER:	Home 5 1	,	-				- 1
d, or	<u></u>	27. MANNER OF DEATN	26a. DATE OF	INJURY	28b. TIME	OF 260	. INJURY AT	-		CRIBE NOW II	NJURY OCC	URED	
fter this c eath with marked,	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, D	ray, reary	INJUF		WORK?	no 🗆					
R: Aff	ED 8	3 Suicide 6 Could not be 4 Nomicide determined	26a, PLACE O building,	F INJURY — At he atc. (Specify)	ome, farm, stre	et, factory,	offica		261. LOCA	ATION (Street a	and Number	or Rural Rout	te Number,
PRECTO Urs aff													
FUNEAL DIRECTOR: After this certificate has been within 72 hours after death with the State Dept. of TANT: If Item 28 Is marked, or Item 23 sho	COMPLET	29a. CERTIFIER (Check only one)											
UNER VIEW	00	2 MEDICAL EXAMINE		xamination and/or	Investigation,	in my opini	on, death oc	cured at the	time, data	and place, and	d due to the	cause(a) ar	nd menner as stated.
TO THE FUNERAL DIRECTOR: After this certificate has been be filed within 72 hours after death with the State Dept. of P IMPORTANT: If Item 28 is marked, or Item 23 sho	8	296. SIGNATURE AND TITLE OF CERTIFIES	hera	ravi	>		29c. L	ICENSE NUM	WBER -	7	29d. DATE	SIGNED (M	onth, Day, Year)
2 6 8 ₹	2	30. NAME AND ADDRESS OF PERSON WH	0 0-0		M 27) (Type, P	rint)	0	100		'	0	119	113
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	Item10e,Film720,2/	15/95,10					20	UL	012		
	1 - STATE OF STATE OF REGISTRAR	MARYLAND / DEPA CERTI	ARTMENT OF	HEALTH AND		IYGIENI REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last)				DEATN			ME OF DEATH			
	William Taft FO	ORD			Februa:	DA 1 1		YEAR	1.6 A M		
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. lest birthde)	y) IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	BIŘTH		B. BIRTHPLAC	E (State or Foreign		
	220-86-1387 1 M 2 F	32 YRS.		HOURS MIN.				Maryl	and		
OR	Franklin Square Hospital		N/		EAIH			y of death Lmore	County		
ទួ	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	140.0	CITY, TOWN OR LOC	471011							
FUNERAL DIRECTOR	MD N/A		altimore				10d. INSIDE CITY LIMITS? 1 XYES 2 N				
¥.	10e. STREET AND NUMBER			Of. ZIP CODE			10g. CITIZI	EN OF WHAT	COUNTRY?		
	9802 Railspin Lane Apt.	L		21220-26	20		U	.S.A.			
5	FORGER	T EVER IN U.S. ARMED		CENDENT OF NISPAI			-		merican Indian, ia, atc.		
ВУ	1 Never Married 2 Married FORCES? IF YES, GIVE	MAR OR DATES		specify Cuban, Mexica S 2 X NO Specif		n, etc.)		Specify:	ia, atc.		
	3 Widowed 4 Divorced			2%				Bla	ack		
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT	'S USUAL OCCUPA'	TION	16b. KIN	D OF BUS	INESS/INDU	STRY			
ш	Elementery/Secondary (0-12) College (1-4 or 5		use retired.)	nost or working							
릴	12th N/A	N/	A		Ret	ail					
COMPLETED	17. FATNER'S NAME (First, Middle, Last)			18. MOTNER'S NA	ME (First, Midd	le Maiden S	Sumame)				
0	Sammie Ford			Cora Ma							
8	19e. INFORMANT'S NAME (Type/Print)	10h MAII II	NO ADDRESS (Street	and Number or Rural			A . T				
9	Cora Mae Ford			Avenue/E							
	20a. METNOD OF DISPOSITION 1X Burial 2 Cremation 3 Removal from State	20b. PLACE AND DAY	E OF DISPOSITION (F DISPOSITION (Name of DATE			DATE 20c. LOCATION — City or Town, Stata				
	4 Donation 5 Other (Specify)	emetery	2-15	Balt	imore	e, MD					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY										
	March Funeral Home East 1101 E. North Avenue/Baltimore, MD 2										
	Jeres - ragic]1101 i	E. North	Avenue	/Balt	imore	∍, MD	21202		
ı	23. PART t. Enter the diseases, or completations the shock, or heart fallura. List only one ca	it caused the death. Do	not antar tha n	oda of dying, suc	h ss cardiac	or reapir	atory arre	et,	Approximata interval Batween		
	IMMEDIATE CAUSE (Final Onset a										
	disease or condition Toxop1	asmosis of	mosis of Central Nervous System					1			
		(OR AS A CONSEQUENCE	OF):					+			
z	Sequentially list conditions, If smy, leading to immediate Aquired Immune Deficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF):										
9											
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):										
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F	resulting in death) LAST										
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_	PART II. Other significant conditions contributing to	death but not resulting	g in the underlyi	ng cause given in	Part I. 24	. WAS AN			AUTOPSY FINDINGS		
5	Renal Insufficiency					PERFORI			ABLE PRIOR TO PLETION OF CAUSE		
						1 TYES 2 TNO			EATH?		
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AN	DID TOBACCO USE CONTRIBUTE TO CA			43	<u> </u>						
Ŭ	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF DE	OTHER:)							
S		☐ ER/Outpatient 3 ☐ DOA		me 5 Reeldenca	8 Other (Sp	ecify)					
- 11	1 YES 2 XNO 1 1 inpatiant 2	INJURY 285 T		IJURY AT ORK?	28d. DEŞCRI	BE NOW IN	JURY OCCU	RED			
E	27. MANNER OF DEATN 28a. DATE OF							4			
IY PHYSICIAN: MEDICAL	27. MANNER OF DEATN 1 Netural 5 Pending 28a. DATE OF (Month, E			YES 2 NO					4		
B≼	27. MANNER OF DEATN 1 Netural 5 Pending (Month, L) 28a. DATE Of (Month, L) 27. MANNER OF DEATN 28a. DATE Of (Month, L)	PF INJURY — At home, ferm	M 1		281. LOCATIO	N (Street er	nd Number or	Rural Route F	lumber,		
B≼	27. MANNER OF DEATN 1 Netural 5 Pending (Month, L) 28a. DATE Of (Month, L) 27. MANNER OF DEATN 28a. DATE Of (Month, L)	lay. Year)	M 1		281. LOCATIO City or To	N (Street er wn, State)	nd Number of	Rural Route F	lumber,		
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) IRGINIA 2. DATE OF DEATN 3. TIME OF DEATH FETTER 199:45 6N55 95 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH s. BIRTHPLACE (State or Foreign 383-20-1432 92 Country 1 🗌 M 2 🔀 F YRS. 0 00-12-ICGINIA 9a. FACILITY NAME (If not institution, give street and number) 6040 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR MGRIDIAN-HAHILTON HAR FORD PRESIDENCE OF DECEDENT BALTO 10a. STATE 10b. COUNTY 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY D.C D.C. Washington 1 X YES 2 | NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3000 Connecticut Ave **APT 330** N-W 20009 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE - American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: BY Specify: 3 Wildowed 4 Divorced WHITE ETED tes. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) ege (1-4 or 5+) COMPL ACCOUNTANT ACCOUNTING 12 4 17. FATHER'S NAME (First, Middle, Last) ts. MOTNER'S NAME (First, Middle, Maiden Surname) Marshall JAMES CROSIN Jennie BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 BUCKHOLDER 2903 CORNUS WAY JOPPA, Md. 21085 20e. METNOD OF DISPOSITION
t Metric 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 28c. LOCATION -- City or Town, State DATE Cemetery FAIRFIELD Spenceport 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES Hereit Bd Balto, Md. 21234 8800 HARFORD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between IMMEDIATE CAUSE (Final Onset and Death beaut disease and Atrice disease or condition resulting in death) Soleme DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION

Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? edrales 1 TYES 2 NO OF DEATH? 1 YES 2 NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) OTHER: HOSPITAL 1 YES 2 NO 1 Inpetient 2 ER/Outpatient 3 DOA ng Home 5 🗆 Residence 8 🗆 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b, TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY 1 Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, atreet, tactory, office building, etc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be

29e. CERTIFIER (Check only t CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) end menner as stated. (Check only one)

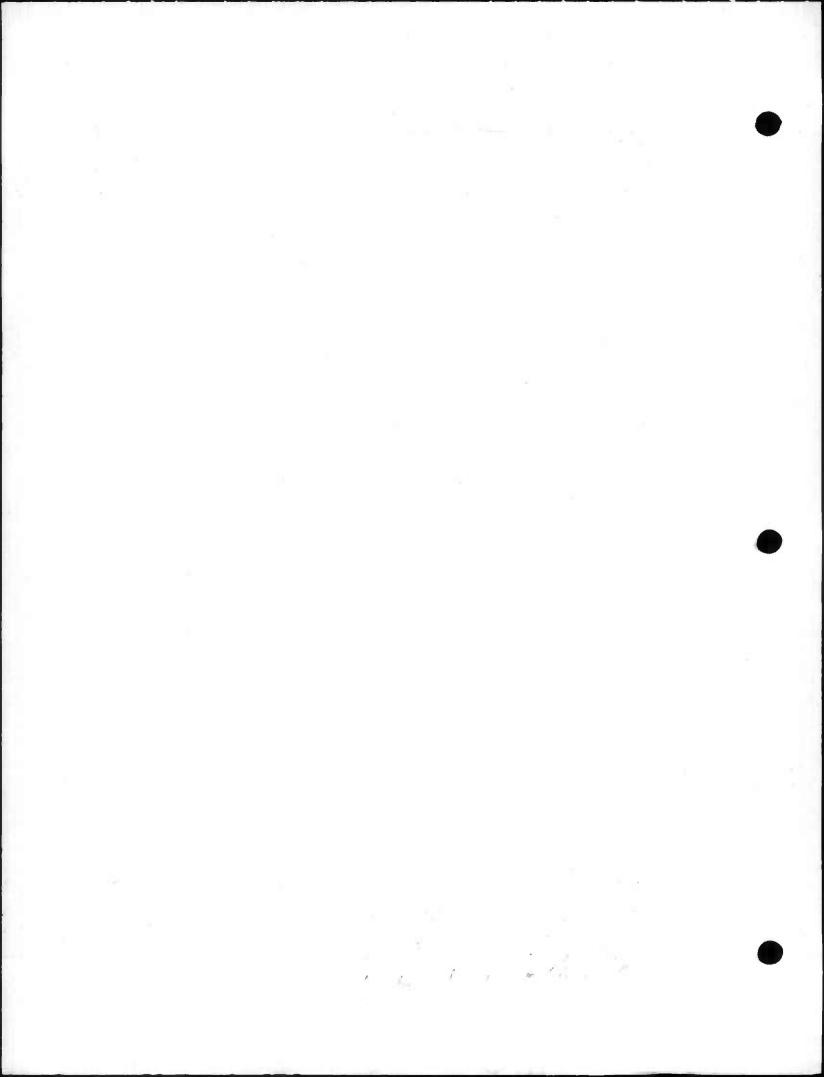
MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER grandouras MA Chu

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

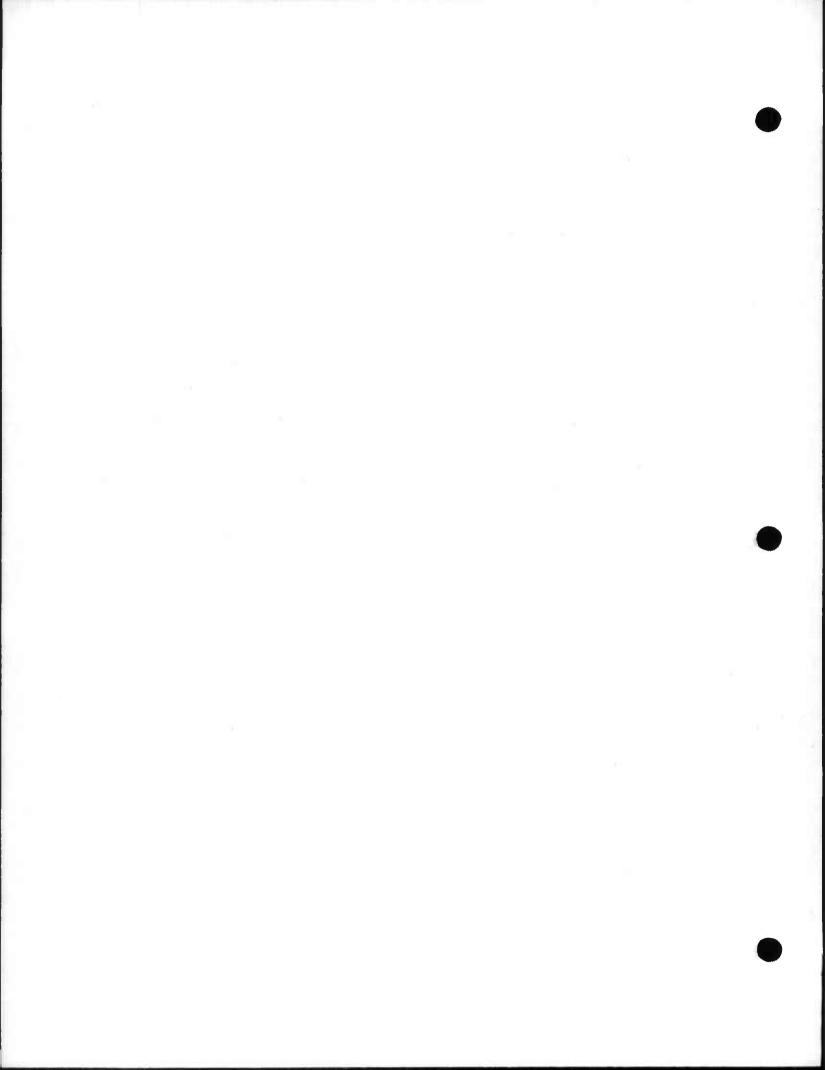
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		1 - STATE OF MARYL REGISTRAR		TMENT OF I		MENTAL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH	
		Emily Pauline Gannon				02-11-95	AY YEA	2:25 a.m. M	
PI		235-60-3186 1□M2∏F	(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 10-18-14	C	RTHPLACE (State or Foreign country) Tyland	
2, 3 should	OR B	9e. FACILITY NAME (If not institution, give street and number) 15624 Bond Mill Road RESIDENCE OF DECEDENT		Laurel	OR LOCATION OF D	EATH	9c. COUNTY C	e George	
t. Pages 1,	DIRECTO	10e. STATE 10b. COUNTY Maryland Prince George		y, TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS? 1 YES 2 X NO	
sit permit.	RAL	10e, STREET AND NUMBER			f. ZIP CODE			OF WHAT COUNTRY?	
-0020 ling physician. the burial-transit	FUNERAL	15624 Bond Mill Road 11. MARITAL STATUS 1 Never Married 2 Merried 12. WAS DECEDENT EVER IF FORCES? 1 YES	IN U.S. ARMED	13. WAS DEC	20707 CENDENT OF HISPA	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	USA or No — 14. B	IACE — American Indian,	
S S S	D BY	3 Wildowed 4 Divorced IF YES, GIVE WAR OR D	DATES	1 🗆 YES	2 X NO Specif	<i>y</i> :	s	White	
	ш	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of w	EDENT'S USUAL OCCUPATION Idea of work done during most of working to NOT use retired.)				SINESS/INDUSTRY	
the hospital or detached for u	COMPLET	8th 0	Homemak	cer		Self			
of the hore be detach	- 1	17. FATHER'S NAME (First, Middle, Last)				AME (First, Middle, Melden			
MARYI retained by 5 should be notified at	BE	William Barnard 190. INFORMANT'S NAME (Type/Print)	Barra Waller			Jane Paug			
40	2	Linda Graver				Route Number, City or Tow Laurel, M			
6 ma ctor, p		1 N Buriel 2 U Cremetion 3 U Removal from State Cer	b. PLACE AND DATE Of metery, cremetory or of urner Cem	ther place)		111105	cation — city o	Town, State Maryland	
_ 0 _ = 1		21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME A	ND ADDRESS OF FA	CILITY		rat y zama	
20 - 2 7		MY COS				Home, Inc		Maryland	
B / 600 Sd within 24 hours after d ompletely filled in by the Li, cremation, or removal.		23. PART I. Entar tha diseases, or complications that cause shock, or heart failure. List only one cause on a IMMEDIATE CAUSE (Final disease or condition resulting in death)	ach lina.	CAR				Approximata Interval Between Onset and Death	
executed and control burial, matic ex	CATION	Sequentially list conditions, it any, leading to immediate cause. Enter UNDERLYING							
th certific ending pt Hygiene or othe	CERTIFIC	CAUSE (Disease or Injury that initiated events resulting in death) LAST							
ing the C	ا ہے	PART II. Other significant conditions contributing to death be	out not reaulting i	n the underlyin	g causa givan in	Part I. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE	
v requires that been signed I	MEDIC						_ NO	OF DEATH?	
law law as b bept.	ä	DID TOBACCO USE CONTRIBUTE TO CAUSE C			UNCERTAI	N 🗆			
The ate ha tate D tate D	YSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Input lent 2 FEVOUT	26. PLACE OF DEAT	OTHER:	5 () Boots	A			
	PHY	27. MANNER OF DEATH 1 Natural 5 Pending 28e. DATE OF INJURY (Month, Day, Year)	28b. TIME	E OF 28c. INJ		8 Other (Specify) 28d. DESCRIBE HOW I	NJURY OCCURED)	
S S S S S S S S S S S S S S S S S S S	EDE	2 Accident Investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY building, etc. (Special Country of the Count	/ — At home, term, s			281. LOCATION (Street (City or Town, State)	and Number or Ru	ral Route Number,	
TAL OR ALL DIRECTS Hours	APLET	29e. CERTIFIER (Check only one)							
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: II	COMPL	2 MEDICAL EXAMINER: On the basis of examination	n end/or investigation	n, in my opinion, d	eath occured at the	time, date end place, an	d due to the ceut	se(e) end manner ea stated.	
TO THE P TO THE P Se filed v	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER			29c LICENSE NUI		29d. DATE SIGN	IED (Month (Day, Year)	
	-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE A . CASAS β β	ATH (ITEM 27) (Type,	Print) NRY L	A. LAG	vez mi)	207	07	
		FEB 1 5 1995 Julia Dauring Contraction of the Contr				·			
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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

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LADING THE SIGNAT. THE ISM ISM	JOR; After this certificate has been signed by the attending ph	after death with the State Dept. of Health and Me	28 is marked, or item 23 shows any injury, or other traumatic event, the medical exami-
)R: 4	ter d	90
	E	at	22

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			MENTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	Goros				2. DATE OF DEATH DAY	VEAD	3. TIME OF DEATN		
	Francisco	pe	e			95	902 P. M			
	4. SOCIAL SECURITY NUMBER 17020256	_	F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	NPLACE (State or Foreign ry) Lippines				
~	9a. FACILITY NAME (If not institution, give street				R LOCATION OF DE		9c. COUNTY OF D			
FUNERAL DIRECTOR	RESIDENCE OF DECEDENT	beneral t	twpmp1	Colum			Howar	٧		
E E	Maryland Prin	ce George	10c. CITY,	Carmad	y Hills		10d. INSIDE CITY LIMITS?			
LD	100. STREET AND NUMBER	ice deorige			ZIP CODE		1 TES 2 NO			
ERA	6601 Seat Pleasant	Drive		100	20743	1/	WHAT COUNTRY?			
S	11. MARITAL STATUS 12	. WAS DECEDENT EVER IN		13. WAS DEC	ENDENT OF NISPAN	IIC ORIGIN? (Specify Yes or	r No— 14. RACE	E — American Indian.		
ВУ Е	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	TE9 NO	If yes, spe		n, Puerto Rican, etc.)	Speci	k, White, atc.		
	15. DECEDENT'S EDUCATION	ON I	16a. DECEDENT'S US	IIIAL OCCUPATION						
COMPLETED	(Specify only highest grade com	oflege (1-4 or 5 +)		k done during mo:		16b. KIND OF BUSIN	IESS/INDUSTRY			
AP.	12	Silege (1-4 or 5+)	Radio	Tech		US Gov	ernment			
Ö	17. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S NAI	ME (First, Middle, Malden Su	rname)			
BE (Thomas Gorospe				Eugenia					
2	19a. INFORMANT'S NAME (Type/Print)					Noute Number, City or Town,		1 2124		
	Cheryl Dercola 20a. METHOD OF DISPOSITION	1 205	PLACE AND DATE OF			Columbia,	Marykan TION — City or To			
	1 Description 1 Description 2 Cremation 3 Removal 4 Donation 5 Other (Specify)		etery, crematory or other			2/15 Suit				
	21. SIGNATURE OF FUNERAL SERVICE LICENS		30000	22. NAME AN	D ADDRESS OF FAC	HUTY FLECK F	uneral	Home, Inc.		
	1 (alax)	Condo		7601	Sandy Sp.	ring Road,	laurel,			
	23. PART I. Entar the diseases, or com- shock, or heart failure. List	plications that dibsed only entrouse on ea	the death. Do not blu line.	antar the mo	da of dying, such	aa cardiac or reapire	fory arrest,	Approximata Interval Between		
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Winom trad infection work sepsis and dehydratin to but to (or as a conscouence of):									
N	Sequentially list conditions, Due to (or as a consequence of): Multiple had stokes Due to (or as a consequence of):									
CERTIFICATION	If any, leading to immediata cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):					' 1		
띮	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):							
FI	resulting in death) LAST									
AL C	PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
S	Coronary cutery	Meene u	du arm	Lun		PERFORME	ED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
PHYSICIAN: MEDIC	Ostwaren					1 TYES 2 M	TNO	DF DEATN?		
z	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH YES	□ NO □	UNCERTAIN	<u></u>				
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	6. PLACE OF DEATN	(Check only one)						
₹		Inpetient 2 - ER/Outpet	itlent 3 DOA 4	☐ Nursing Nome	5 🗆 Rasidenca					
	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME C	Y WOI		28d. DESCRIBE NOW INJU	URY OCCURED			
BY	2 Accident Investigation 3 Suicida 8 Could not be	28a. PLACE OF INJURY	— At home, farm, atre		23 2 1 110	26f. LOCATION (Street and	Number or Rural F	Route Number.		
COMPLETED	4 Nomicide determined	building, etc. (Speci	fy)			City or Town, State)				
2	29a. CERTIFIER 1 CERTIFYING PHYSICIAN	: To the best of my knowle	edge, death occurred a	it the time, date	and place, end dua	to the cause(s) and manne	r as stated.			
S O	one) 2 MEDICAL EXAMINER: O) and manner as stated.		
B	294 SIGNATURE AND TITLE OF CERTIFIED	u mi)			29c. LICENSE NUM	BER 2	Pad. DATE SIGNED	(Month, Day, Year)		
요	30. NAME AND ADDRESS OF PERSON WHO CO	MINLETED CAUSE OF DEA	TN (ITEM 27) (Type. Pr	M 11 0	YIVE S	Ellicott Ci	ty m	D 21042		
	31 FEB 1 5 1995 Julia	JAMES LEAVE AND ALEAS	THE							



L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-train hours after death with the State Deot, of Health and Mental Hydiene prior to burial, cremation, or remonal.	item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR GRACE MAXINE GARRETT February 13,1995 1:00 A 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 05 04 29 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign West Virginia 234 46 3403 1 M 2 X 65 YRS. 9e. FACILITY NAME (if not institution, give street end number, 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OFATH 806 South Dean Street DIRECTOR Baltimore City RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY Md. Baltimore City 1 YES 2 | NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 806 South Dean Street 21224 USA 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE - American Indian, Black, White, etc. 1 Never Merried 2 X Merried BY 3 Widowed 4 Divorced Whice ETED. 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) At Home Housework COMPL 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surneme) Henry David Curtis notified af A nna Olive Burkhammer ш B 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Milton W.Garrett 806 S.Dean St. Balto., Md. 21224 20a. METHOD OF DISPOSITION
1 State | 2 | Cremetion | 3 | Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State cemetery, cremetory or other place) 2-16-95 Oak Lawn Cemetery 2-10-7 Eastwood, Md. 4 Donetion 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles S.Zeiler & Son Inc. 901 S.Conkling St. Balto Md 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata shock, or haart failura. List only one cause on each line. Interval Batween IMMEDIATE CAUSE (Final Onset and Dasth disease or condition resulting in death) CERTIFICATION Sequantially list conditiona, DUE TO (OR AS A CONSEQUENCE OF if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMEDS: MEDICAL 1 - YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PHYSICIAN: UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only o EXAMINER? HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Home 5 Gesidence 6 ☐ Other (Specify) 27. MANNES OF DEATH 28c. INJURY AT WORK?
1 YES 2 NO 26e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED Natural BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, etc. (Specify) 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be COMPLETED 4 Homicide 29e CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated. 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end piece, end due to the ceuse(e) end manner ee stated. 29b. SIGNATURE AND TITLE DE CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Ch m

2112 DYMPAUC AVE.

BELINDA 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE FEB 1 5 1995

30. NAME AND ADDRESS OF PERSON WHO/COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

BALTIMORE, MARYLAND 21215-0020	of PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	Ander this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.	madical avaminar must be settled at occa-
ON OF VITAL RECORDS, P.O. BOX 68760	PHYSICIAN: The law requires that the death certificate be executed with	Ther this certificate has been signed by the attending physician and completely filled in by the infinite with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	marked or them 23 shows any interview traumatic event the medical evanines must be matitied at assess
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31. DATE FILED (Month, Day, Year)

32. REGISTRAR'S SIGNATURE Durchartadell

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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'SANAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JOODMIN D 2 1 antie 1501- H 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS une 1 😾 M 2 🗌 F YRS. 251-24-1219 ΪĠ Juno South Carolina 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Bon Secours Hospital Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1 X YES 2 NO FUNERAL toe. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 104 Wheeler Avenue 21223 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 2 NO 1 TES 2 NO Specify: B Specify: 3 Widowed 4 Divorced Bl.ack COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16h KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade Construction B & O Railroad 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Wesley Goodman BE Julia Taylor 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2 Donald Goodman 104 Wheeler Avenue Baltimore, Maryland 21223 20s. METHOD OF DISPOSITION

1 WBurlel 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Feb. 20c. LOCATION - City or Town, State King Memorial Park 15 Baltimore County, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Ulus Baltimore, Maryland 21215 23. PART I. Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, wheart fellure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Finel Onset and Death diseese or condition resulting in death) ORDER DUE TO /OR AS A CON EQUENCE OF: AP47 CERTIFICATION Sequentielly list conditions, CE OF) DUE TO (OR AS A CO if sny, lesding to immediate MEROROUS CSUSA, Enter UNDERLYING CAUSE (Diseese or Injury that initiated events DUE TO JOR AS A CONSEQUENCE OF resulting in death) LAST PART ii. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 □ NO 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL **EXAMINER?** OTHER: t TYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town: State) 6 Could not be COMPLETED 4 Homicide 29e. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as attated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) TO THE DE FINAL DE PROPERTIES BE -25 84143 -13 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MMA MO 502

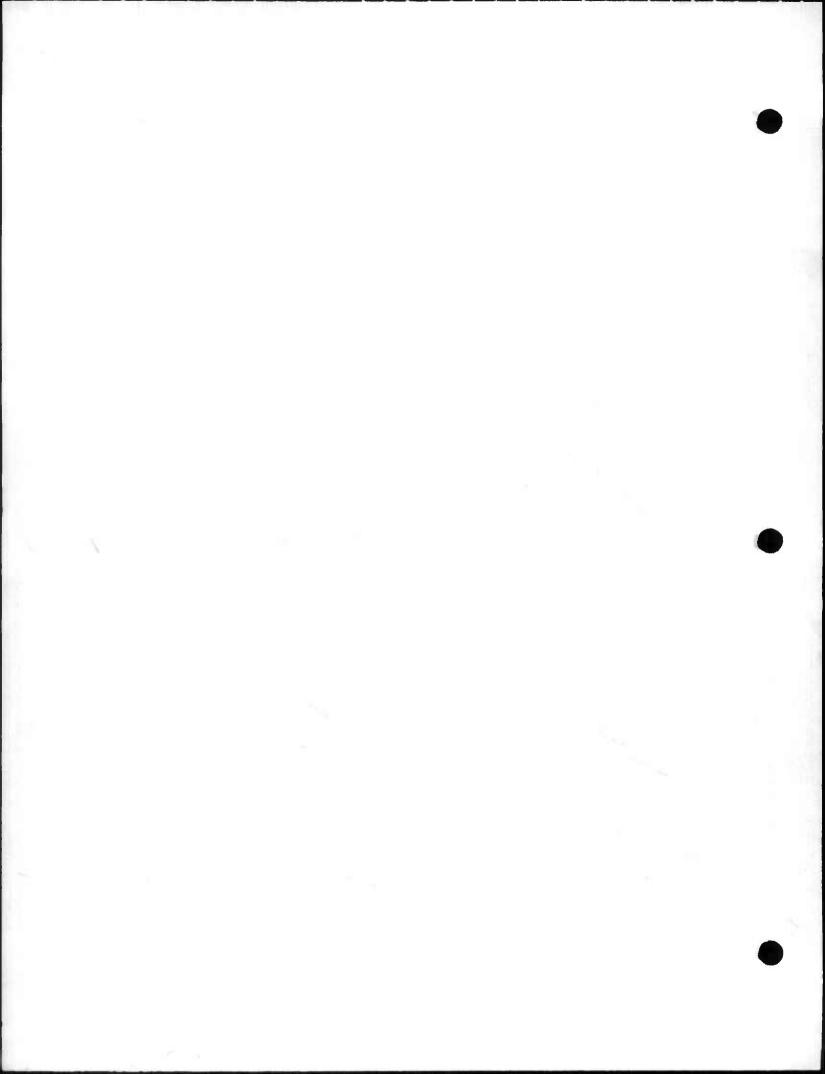
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I	9a. FACILITY
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F	11. MARITAL
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR		CE	RTIF	CATE OF	DEATH	RE	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Lest)						2. DATE OF D	EATH DA			3. TIME OF DEATH
	Auldean M.	Geller					Februa			1995	7:00 A. M
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. last	birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF B	MATH		S. BIRTH	IPLACE (State or Formian
	218-03-6731	1 🗌 M 2 💢 F	77	YRS.	MONTHS DAYS	HOURS MIN.	Jan.	19	18	Man	yland
	9e. FACILITY NAME (If not institution, give :	street and number)			9b. CITY, TOWN	OR LOCATION OF D				NTY OF D	J
R	3005 Andover Road Forest Hill Harford							^d			
5	RESIDENCE OF DECEDENT			1					110	11101	
DIRECTOR	LIMITS							10d. INSIDE CITY			
		rford			Forest	Hill					1 TYES 2 X NO
4	10e. STREET AND NUMBER				10	. ZIP CODE			10g. CIT	IZEN OF W	VHAT COUNTRY?
FUNERAL	3005 Andover Road 21050 U.S				5.A.						
ا ۾	11. MARITAL STATUS	12. WAS DECEDENT EX FORCES? 1	ER IN U.S. ARM	ED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Sp	ecity Yes	or No-	14. RACE	- American Indian,
BY	1 Never Married 2 Married 3 Vidowed 4 Divorced	IF YES, GIVE WAR	OR DATES	,		ecify Cuban, Maxico		, etc.)		Specif	fv:
											White
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	completed)	(Give	e kind of w	OSUAL OCCUPATE ork done during me	ON ist of working	16b. KIND	OF BUS	ANESS/INC	USTRY	
ا ت	Elementary/Secondary (0-12)	College (1-4 or 5+)		Do NOT us			1,77	c (٦ ٥		
\$	12th grade		5	ecre	tary					cnmen	I.C
8	Melville H. Sl	nuchtor				18. MOTHER'S NA			Surname)		
BE		augnter		_			Mae Mer				
9	19a. INFORMANT'S NAME (Type/Print)	(1 1	4			nd Number or Rural					
	William R. Gell	er (nusband	_			r Road,					.050
	20g. METHOD OF DISPOSITION 1 N Burlai 2 Cremation 3 Rem	oval from State	cemetery, crem	atory or of	F DISPOSITION (Na		DATE				
	4 Donation 5 Other (Specify)		Bel Ai	r Me	morial	Gardens		Be1	Air,	Mar	yland
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			Schi	nunek Fu	neral H	iome s	z Tr	10	
	127	M				Belair			-		21236
	23. PART L Enter the diseases, or	complications that ca	used the dea	th. Do n	ot enter the mo	de of dying, suc	ch as cardiac o	or raspi	ratory an	rest,	Approximata
	snock, or heart failure. List only one ceuse on each line.						Interval Between Onset and Death				
	disease or condition	PA	W CK	EX	777c	CAN	CER	_			18 MON
- 1	resulting in death)	B+	AS A CONSEQU								10/1/0/0
z	-										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEQUENCE OF):									
8	CAUSE (Disease or Injury	E									
E	that initiated events	DUE TO (OR	AS A CONSEQU	PENCE OF	k.						
E	resulting in death) LAST	d									
0	PART II. Other significant condition	s contribution to des	th but not re-	andrine le	the underlyin		not In			Local	
DICAL	7-7133 III GUINI PAGINICALE CONSTITUTI	is continuoung to dea	in out not re	nuiting is	the underlyin	g cause given in		WAS AN A		24b.	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO
ă							- 10	YES 2	to Mo		COMPLETION OF CAUSE OF CEATH?
ME											1 TES 2 NO
PHYSICIAN:	DID TOBACCO USE CONT	RIBUTE TO CAUS				UNCERTAI	и 🗆 📗				
2	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMPLED THER:										
YS	1 □ YES 2 MO	1 Inpetion 2 I ER			4 - Nursing Hon	e 5 El Residence	6 🗆 Other (Spe	ойуг			
E.	1 Natural 5 Pending	(Month, Day, H		28b. TIME INJU	MA. MC	PHC?	26d. DESCRIBE	E HOW IN	JURY OCC	CUMED	
B	2 Accident Investigation M 1 YES 2 MO										
E	U 4 Homicide determined										
릴	(Check only 1 CENTSFYING PHYSI	CLAN: To the best of my	knowledge, sleet	N occume	d at the time, date	and place, and due	to the cause(s)	and man	ner se stat	ed.	
COMPLETED	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as attated.										
W/	29th. SIGNATURE AND TITLE OF CENTURES 1										
19	DZ1775 FEBRUARY 13m										
7	30. NAME/AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										
/	Dr. Joan Edwards, 2112 Belair Rd., Suite 4-A, Fallston, MD 21047										
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE										
	FEB 1 5 1995 July Stewison Roll 11										
	1 0 1.777 20	AND RIBINETANA	0 . 0 . 00								



THE FINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be made after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. THE POST TAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 INPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 -	FOR STATE REGISTRAR
	REGISTRAR

	REGISTRAR		CI	ERTIF	ICATI	E OF	DEA	TH		REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)									OF DEATH			3. TIME OF DEATH	
	NATHANIEL				Н	IGG	S	III	MONT F	EB.	11	95	10:24A	M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les		IF UNDER	1 YEAR	IF UNDE	R 24 HRS.	7. DATE (Mont)	OF BIRTH		a BIRTHS	PLACE (State or Foreig	n
	214-15-1915	1 X XM 2 □ F	14	YRS.						23, 19	80	BAL	TIMORE, ME)
œ	9a. FACILITY NAME (If not institution, give a JOHNS HOPKIN		TAT					ION OF O	EATH		9c. COU	NTY OF DE		
DIRECTOR	RESIDENCE OF DECEDENT	5 HOSFI	TAL		D.	ALL	TMOI	KE C	TIX			n/	a	
E	10a. STATE 10b. COUNTY	7		10c. CIT	Y, TOWN (OR LOCAT	TION						10d. INSIDE CITY	
5	MARYLAND	n/a			BA	LTI	MORE						LIMITS?	
AL	10e. STREET AND NUMBER					101	ZIP COD					ZEN OF W	HAT COUNTRY?	
FUNERAL	1401 N. DECKE	R AVENU	E				21	213			UNIT	TE D	STATES	
5	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AR	MED						t? (Specify Yes	or No-	14. RACE	- American Indian, White, etc.	
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES X	X				Specif		rican, etc.)		Specify		
	15. DECEDENT'S EQU	CATION	16a DE	CEDENT'S	HEHAL O	CCURATIO			140	. KINO OF BU	000500	MATERIA	DLACK	
	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5 +	(G	ive kind of v Do NOT us	work done	during mo	st of worki	ing	100	KINO OF BU	SINESS/INL	JUSTRY		
릴	9 TH		'	STUD	ENT					n/a				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOT	HER'S NA	ME (First, I	Middle, Maiden	Surname)			
BE 0	NATHANIEL HI	GGS JR	•					AN	GELA	G.	G1	LLIA	M	
10 B	19a. INFORMANT'S NAME (Type/Print)	000 10	196	. MAILINO		(Street a	nd Numbe	r or Rural	Route Numi	ber, City or Tow	n, State, Zip	Code)		
٢		GGS JR	•	1401	N.	DE	CKER	STI	REET,	, BALT	IMORE	, MD	21213	
	20a. METHOD OF DISPOSITION XIX Burial 2 Cremation 3 Rame	oval from State	20b. PLACE	AND OATE	OF DISPOS	ITION (Na	me of		DAT	E 20c. LO	CATION —	City or Tow	rn, Steta	
	4 Donation 5 Other (Specify)		GARR	ISUN				_		L7 OW	INGS	MILL	S, MD	
ľ	21. SIGNATURE OF PUNERAL SERVICE LIC	A L	1		22.	NAME AN	ID ADDRE	SS OF FA	CILITY					
	1/ Marell	esto"	TIME	0						-1101			AVE.	
Ì	23. PART i. Enter the diseases, pro ahock, or heart feliure.	complications that	caused the de	eth. Do n	ot enter	the mo	de of dy	ing, suc	h as card	flac or reapl	ratory arr	est,	Approximate	
	IMMEDIATE CAUSE (Finei	and only one cue.	or on each mile	1									Onset and De	
	disesse or condition a. HANGING													
	DUE TO (OR AS A CONSEQUENCE OF):													
S I	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):													
¥	if sny, leeding to immediate cause. Enter UNDERLYING	DUE 10 (OR AS A CONSEC	DUENCE OF	-):									- 1
윤	CAUSE (Disease or injury that initieted events	DUE TO (OR AS A CONSEC	DUENCE OF	F):									
CERTIFICATION	resulting in deeth) LAST												İ	- 1
2	DARY II Oshan significant and state												1	
EDICAL	PART ii. Other significant condition	s contributing to	death but not r	ecuiting I	n the un	deriying	Csuse	given in	Part i.	24a. WAS AN PERFOR			WERE AUTOPSY FINDIN AWAILABLE PRIOR TO	
ă									_	1 YES 2	□ NO		COMPLETION OF CAUS OF DEATH?	ε
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AN	DID TOBACCO USE CONTE	SIBUIE TO CAL					UNC	ERTAI	ИП					
ᅙ	EXAMINER?	HOSPITAL:		E OF OEAT	OTHER	3:		-11						-
PHYSICIAN:	1 TYES 2 NO 27. MANNER OF DEATH	1 Inpetient 2XI		28b. TIM		alng Hom- 28c. INJ		rsidence	8 Othe					_
	1 Natural 5 Pending	2 10 G	y. Yogr)	INJ	URY G DM	1 Y	RK?	(NO	280. DES	CRIBE HOW I	0			
B	2 Accident Investigation 3 Suicide 8 Could not be	2	v)	-	\rightarrow			Alio	281 LOC	ATION (Street o	SE Sent Number		uita Mumbas III	
	U 4 ☐ Homicide determined determ						2							
The Appropriate						114								
ğ							. 1							
B	MINH	HVO	At										Month, Day, Ybar)	
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	EIGH BEATH (ITER	1 27) (Type	Print)				M.E.		-	EB.	12/95	_
1		EJKIM	111 P	enn	Str	eet	, Ba	lti	more	e, Ma	ryla	nd 2	21201	
	31. OATE FILED (Month, Day, Year)	32. REGISTRAF	'S SIGNATURE											
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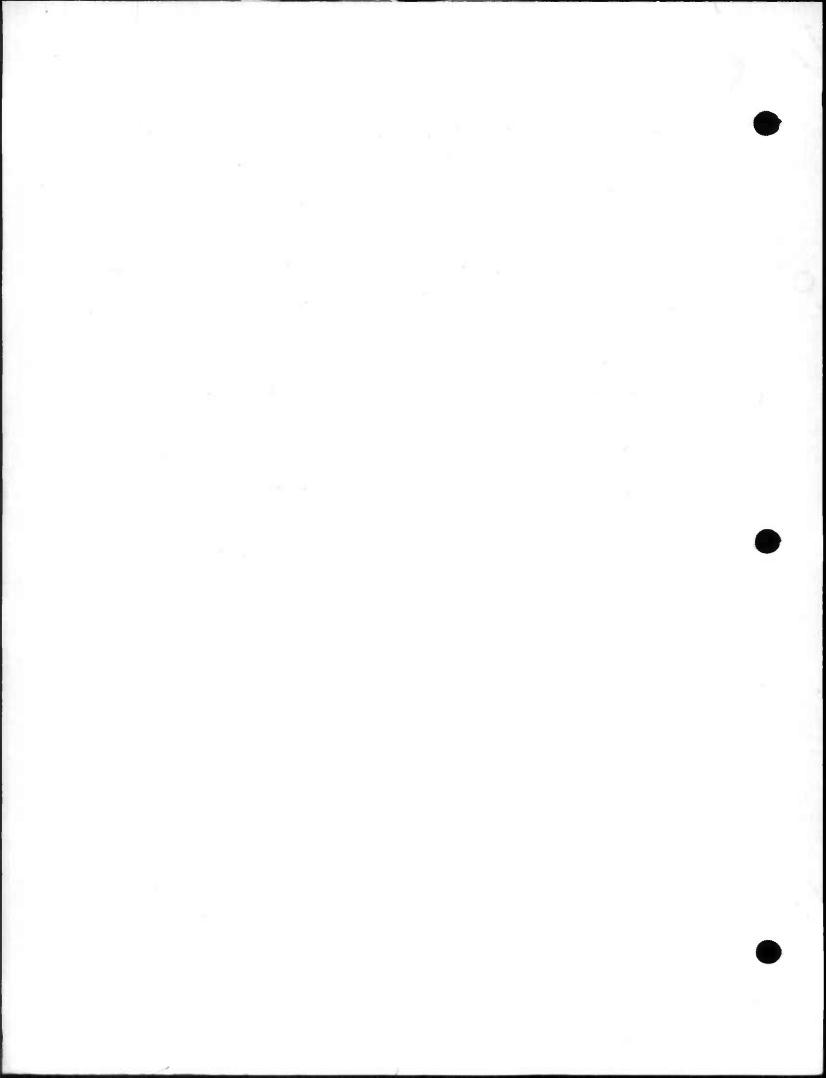
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

EDICAL CEDITICION TO DE COMPLETED DY CINICAL DIOPETRO	NE II Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	Health and Mental Hygiene prior to burial, cremation, or removal.	INRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	NSICIAN: The law requires that the death cartificate be executed within a forum after death. Page 6 may be retained by the hospital or attending physician.	
O BE COMPLETED BY BUYSICIAN: MEDICAL CERTIFICATION	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other trau	where with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IN THE FUNCHAL DIRECTOR: After this certificate has been signed by the attending physicia	TO THE MISPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be	

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			ENTAL HYGIENI REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)				2	DATE OF DEATH		3. TIME OF DEATH
	LAWRENCE	JOHN H	OLTON			FEB 10	1995	м
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE ((in yrs. lest birthday)	UNDER 1 YEAR		DATE OF BIRTH	6. BIRT	THPLACE (State or Foreign
	705-10-9199 Pa. FACILITY NAME (# not institution, give s	1 M 2 F 9	J YRS.		LOCATION OF DEAT		9c. COUNTY OF	Md.
FUNERAL DIRECTOR	Meridian Lock	0			CKVILLE	n	-	imore
EG	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	γ	10c, CITY, T	OWN OR LOCATIO				10d. INSIDE CITY
E I	Md			Baltim				LIMITS?
Ĺ	10e. STREET AND NUMBER				ZIP CODE		100 CITIZEN OF	1 X YES 2 NO
R	64011 00 4 RA	WEN BIND.			21206		US	
Ž	11. MARITAL STATUS	12. WAS DECEDENT EVER IF	N U.S. ARMED	13. WAS DECE		ORIGIN? (Specify Yes		CE — American Indian,
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	If yes, spec	Ify Cuban, Maxican, I	Puarto Rican, etc.)	Ble	ck, White, atc.
ВҰ	3 Widowed 4 Divorced			1 123	г цамо зресну		14/	bite
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade		16a. DECEDENT'S US	UAL OCCUPATION	of unching	166. KIND OF BUS	INESS/INDUSTRY	
H	Elementary/Secondary (0-12)	College (1-4 or 5+)		done during most etired.)	or working	2		
MP	UNKNOWN		Freight	CONDI	CTOR	MAILR	DAD	
8	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NAME	(First, Middle, Maiden	Surname)	
BE		DLTON			ERIC	A KNO	OBLE	
2	19a. INFORMANT'S NAME (Type/Print)	0	19b. MAILINO AD	ORESS (Street and	d Number or Rural Rou	te Number, City or Town	n, Stere, Zip Code)	
		POLAR	7 Gay	ndson	Cr. UNI	1201 TIN	MUINO!	Nd. 21093
	20a. METHOD OF DISPOSITION 1 Durial 2 Cremation 3 Rem		PLACE AND DATE OF Detery, crematory or other				CATION — City or	Town, Stata
1	4 Donation 6 Other (Specify) 21. SIONATURE OF FUNERAL SERVICE LIC		areen Mo		ADDRESS OF FACIL	4/1/95 Bo	uto. Ma	3
	()	0				of Chimes		
	Gradent (C)	Lieved	1	2325	York Rd.	TIMENIO	m. Md.	21093
	23. PART I. Enter the dieeeses, or eshock, or heart failure.	complications that caused Liet only one cause on a	d the death. Do not	enter the mod	e of dying, euch a	s cerdiec or respi	ratory errest,	Approximate Interval Between
	IMMEDIATE CAUSE (Final	λ.	α			\		Onset and Death
	disease or condition resulting in death)	. ARTERIOSCI	LEROTIK Y	12DIOUA	scucar V	BEASE		Lour
		DUE TO (OR AS A	CONSEQUENCE OF):					1
ON	Sequentially list conditions,	b	CONSEQUENCE OF):					
AT	If any, leading to immediate cause. Enter UNDERLYING	55E 10 (ON A5 A	CONSECUENCE OF).					
임	CAUSE (Disease or Injury that initiated events	C. OUE TO (OR AS #	CONSEQUENCE OF):					<u> </u>
CERTIFICATION	resulting in deeth) LAST	d						
	DART II. Other significant condition							
NA	PART II. Other significant condition	is contributing to death b	out not resulting in t	the underlying	cause given in Pa	rt i. 24a. WAS AN PERFOR		Ib. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă						_ 1 YES 2	□ NO	OF DEATH?
Σ			-			-		1 TYES 2 NO
Ä	25. WAS CASE REFERRED TO MEDICAL							
PHYSICIAN: MEDIC	EXAMINER?	HOSPITAL:	0	THER:	CE OF DEATH (Check			
Ĭ.	27. MANNER OF DEATH	28a. DATE OF INJURY	26b. TIME O		5 Rasidence 6	Other (Specify) 8d. DESCRIBE HOW II	JURY OCCURED	
	1 Natural 5 Pending	(Month, Day, Year)	INJUR	Y WOR				
) BY	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY	— At home, farm, stre-			Bf. LOCATION (Street a	nd Number or Rura	I Floute Number,
Ë	4 Homicida determined	building, atc. (Spec	опу)			City or Town, State)		
LE	(Check only 1 CERTIFYING PHYSI	GLAM: To the beat of my know	ledge, death occurred a	it the time, data a	nd place, and due to	the cause(s) and man	ner se eteled	
COMPLETED	MEDICAL EXCENSINE	ER: On the beels of examination	n and/or investigation, i	n my opinion, das	ath occured at the tim	e, data and place, and	d dua to the cause	(a) and manner as stated.
	296 SHONATURE AND TYPLE OF CERTIFIER				294 LICENSE NUMBE			D (Month, Day, Voar)
BE (ta It				W-170c	((10 €	195
2	30, NAME AND ADDRESS OF PERSON WH	O COMPLETEO CAUSE OF OE		(nt)	1 -			- ()
4	March L	eaver my)	76020	sler W	rive 2	21204		
	31. OATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN						
	FEB 1 5 1995	Tella Davolson Re	rdall					

DHMH-16 Rev 1/89



ATE TO THE SOLAN: The law requires that the death cartificate be executed within 1.5 hours after death. Page 6 may be retained by the hospital or attending physician.

THE ALL THE THE PASS DEATH OF HEALTH SPACES AND SOLID SPACES AND SOLID SPACES AND SOLID SPACES.

THE PASS DEATH OF STATE DEAT. OF HEALTH AND MENTAL Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

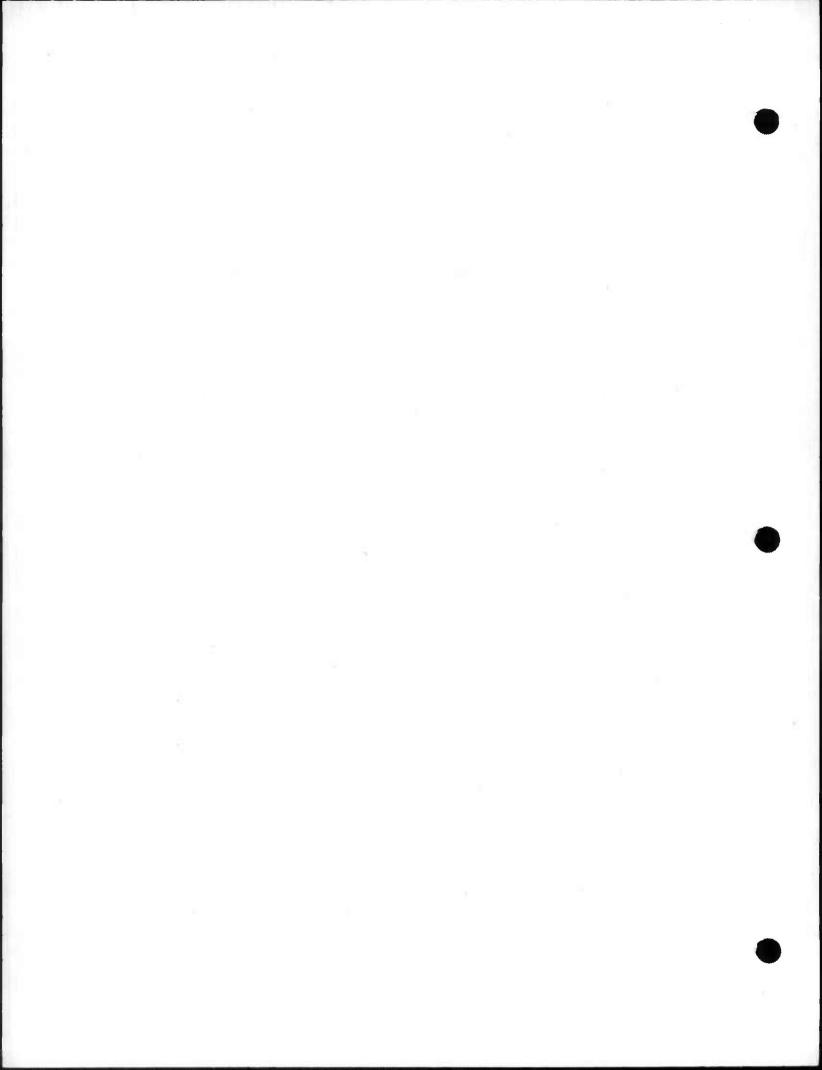
VISTON OF VITAL RECORDS, P.O. BOX 68760

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

- 5	1 - STATE REGISTRAR	C			F DEATH	WILLIAM.	REG. NO	_			
í	1. DECEDENT'S NAME (First, Middle, Lest)	-					E OF DEATH		VEAR	3. TIME OF DEA	TH
	CHARLES	S.		HINS		FE	B 13	3 1	995	7:04	A
	010 20 000	6. AGE (In yrs. Is	YRS.	IF UNDER 1 YEAR MONTHS DAYS			Y 21 1	962	8, BIRTH Countr	IPLACE (State or F	oreign
OB OB	99. FACILITY NAME (If not institution, give street and number) 99. CITY, TOWN OR LOCATION OF DEATH 90. COUNTY OF DEATH 90. COUNTY OF DEATH										
	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LO	ATION					10d. INSIDE CIT	
DIRECTOR	MD			BALTIM						LIMITS?	
FUNERAL	10e. STREET AND NUMBER	000 070557		T	10f. ZIP CODE			10g. CIT	IZEN OF V	VHAT COUNTRY?	
	2002 N. SMALLW				21216				JSA		
BY FU	11 Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S.A. FORCES? 1 YES 2 THE SET OF THE SET		If yes,	ECENDENT OF HISP specify Cuben, Maxi ES 2 XXNO Spec	can, Puert		or No—	14. RACE Black Speci	E — American Ind c, White, etc.	
	15. DECEDENT'S EDUCAT (Specify only highest grade col	TION 16a. D	ECEDENT'S	USUAL OCCUPA	TION	.10	66. KIND OF BU	BINESS/IN	DUSTRY	DENOR	
COMPLETED	Elementary/Secondary (0-12)		ia. Do NOT us	work done during se retired.)	most of working						
g I	17. FATHER'S NAME (First, Middle, Last)				All the second second second		, Middle, Malden	,			
	CARLOS HUTCHINS					_	GAFFN				
2	190. INFORMANT'S NAME (Type/Print) WILLIAM CARLOS				t and Number or Rura OLK AVE		ALTO.	n, State, Zi		216	
	20e.WETHOD OF DISPOSITION 1 Burial 2 Cremation 3 Remove	20b.PLACE	ANDDATE	OF DISPOSITION	Neme of				City or To		_
- [4 Donation 6 Other (Specify)	ARBUTUS	MEMOF	RIAL PARK		218	95 BA	LTO	. MC)	
ı	21. SIGNATURE OF FUNERAL SERVICE LICEN	5. Scott	_	MARC	H FUNER	ACILITY A L	HOME - N		. MC	2121	1.5
7	23. PART/I. Enter the diseeses, or con	nplications that caused the d	leath. Do r	not antar the n	node of dying, au	ch as ca	rdiec or respi			Approxim	_
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Multiple DUE TO (OR AS A CONSE		Sho	+ wo	und	,s	- 40		Interval E Onset an	
NON	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING										
CEMINIFICATION	CAUSE (Disease or Injury that initiated events resulting in daath) LAST	DUE TO (OR AS A CONSE	EOUENCE OF	F):							
DICAL	PART II. Other algolificant conditions of	contributing to deeth but not	resulting (in the underly	ng ceusa given l	n Part I.	24a. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY F AVAILABLE PRIOR COMPLETION OF	10
ME										OF DEATH?	NO
	DID TOBACCO USE CONTRIE					IN 🗆					
PHTSICIAN:		OSPITAL:		OTHER:							
	XXVES 2 NO 1	☐ Inpetiant 2 ☐ ER/Outpatient :	3 DOA		ome 5 - Residence		er (Specify) S			LAYGRO	UND
1	1 Natural 5 Pending	Found 2-13-95		URY	YES 2 -NO	50	Kest	5/	~L		
	3 Suicide 6 Could not be 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)										
	4 Homicide detarmined		(4991	rund			400 h	1 E	uan	ont St	
COMPLEIED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA 2 MEDICAL EXAMINER: (N: To the best of my knowledge, d On the besis of exemplation and/or	eath occurre	ed at the time, da	te and place, and du	e to the c	ause(a) and man	ner as ata d due lo ti	ted. he cause(a)	and manner as a	ntated.
u II	29b. SIGNATURE AND TITLE OF CERTIFIER	Mili			29c. LICENSE NI					(Month, Day, Year)	
		Whi			1 0.C.	M.E			EB.	13.199	
-	30. NAME AND ADDRESS OF PERSON WHO C										
-	130010 R TO		Pen	n Stre	eet, Ba	Ltim	ore,	Mary	Land	1 2120	1
-	-EB 1 5 1995 Have d	PROFESION SOLATURE									

TO THE HOSPITAL (R.A. TO THE FUNERAL CHER be filed within 72 hour important;. If Illum



	Ιt	empombFilm720,2. 1 - STATE REGISTRAR	1 STATE OF MARYL	AND / DEPAR	RTMENT OF I	HEALTH AND	MENTAL HYGIEN REG. NO	E	
		1. DECEDENT'S NAME (First, Middle, Lest) 4. SOCIAL SECURITY NUMBER	12abeth	Hotel)		2. DATE OF DEATH MONTH DI	12,190	
pino		9a. FACILITY NAME (If not institution, give st	1 🗆 M 2 💢 F	YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN. OR LOCATION OF D			BIRTHPLACE (State or Foreign Country) Maryland
1, 2, 3 should	стов	Union Memori		1		ltimore		9c. COUNTY	OF DEATH
permit, Pages 1,	DIRE	Maryland 10b. COUNTY	Baltimore	10c. CIT	TY, TOWN OR LOCA		sex		10d. INSIDE CITY LIMITS? 1 YES 2 X NO
Sit	NERAL		E. Hadwick				21221	Ur	nited States
5-0020 nding physician. ss the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	If yea, sp	CENDENT OF HISPA pecify Cuban, Maxic 3 2 X NO Speci	NIC ORIGIN? (Specify Yea an, Puarto Rican, etc.) fy:	n or No— 14.	RACE — American Indian, Black, White, etc. Specify: White
al or atte	LETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondery (0-12)					16b. KIND OF BUS	SINESS/INDUS	TRY
be det	E COMPL	17. FATHER'S NAME (First, Middle, Last)	Michael Ray		zent		AME (First, Middle, Maiden arie Bremer		
MAH e retained 5 should notified	TO BI	190. INFORMANT'S NAME (Type/Print) Michael R. Hatch			ADDRESS (Street of E. Hadv	and Number or Rural	Floute Number, City or Tow	n, State, Zip Co	Maryland 21221
		20a. METHOD OF DISPOSITION 1 (X Burlei 2 Cremation 3 Remo 4 Donetion 5 Other (Specify)	val from State Cem		of disposition (Na other place) Men	morial 2	/16/95 Tir		or Town, State Maryland
SAL I r death. re funeral. al.		21. SIGNATURE OF FUNERAL SERVICE LICE	Knight	Knight Ji	5305	ND ADDRESS OF FA	Rd. Baltir	more, I	Ruck, Inc. Md. 21214
by filled in the string of the		23. PART I. Enter the diseases, or abook, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	Preterm	ach line.		oda of dylng, aud	ch as cardiac or reapl	Iratory arreat	Approximate Interval Batween Onset and Death
certificate be execuding physician and tygiene prior to burn other traumatif	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	PF):				
	EDICAL CEI	PART II. Other algnificant conditions	contributing to death be	ut not resulting	in the underlyin	g cause given in	Part i. 24s. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
been been of sh	Σ	DID TOBACCO USE CONTR				UNCERTAI	N 🗆		1 TYES 2 NO
	YSICIAN	EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER: 4 Nursing Hore	ne 5 🗆 Raaldenca	8 Other (Specify)		
re tits	ву рну	27. MANNER OF OEATH 1 Netural 5 Pending 2 Accident Investigation	28s. OATE OF INJURY (Month, Day, Year)		M t	ORK? YES 2 NO	28d. DESCRIBE HOW II	NJURY OCCUR	ED
A ATTENDING RECTOR: After urs after death m 28 is ma	ETED	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Speci	ffy)			28t. LOCATION (Street a City or Town, State)		Rural Route Number,
TO THE HOSPITAL DR ATTENDING TO THE FUNERAL DIRECTOR; After be filed within 72 hours after death IMPORTANT; It item 28 is ma	COMPL	one) 2 MEDICAL EXAMINER	IAN: To the best of my knowler. On the basis of exemination						suse(a) and menner as stated.
TO THE P. TO THE P. De filed w	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 130. NAME AND ADDRESS OF PERSON WHO	in W	TH 475M AT (T		ATAL	MBER 138946	29d. DATE SI	GNED (Month, Day, Year) ruary 14,1995
į		Clara Herrir	Union	Memor	1 11	rpital	Baltim	ore.	md.
		31. DATE FILED (Moeth, Day, Ybar) 1995	22. REGISTRAR'S SIGNA	Rardall		,			

. TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a first feath. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

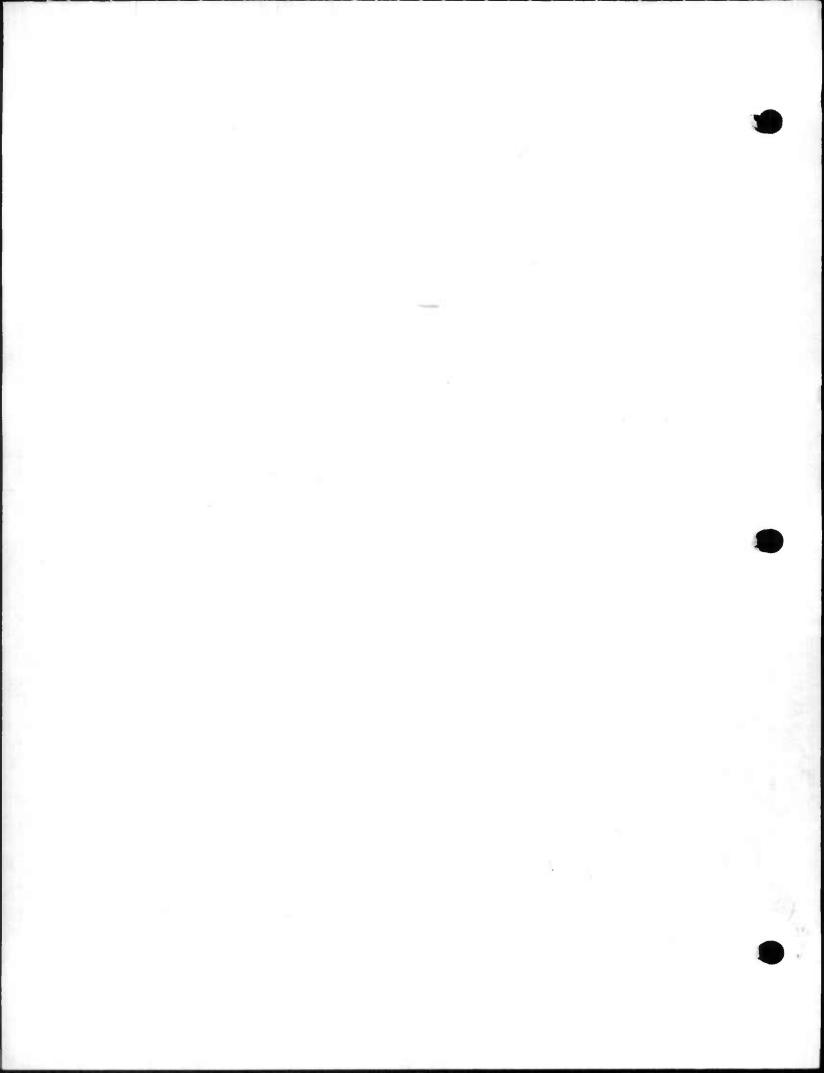
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1	•	STA		RAR
į	1	. D	ECEDI	NT'S	NA
		(Wil	li	aı

	REGISTRAR	CERTIFIC	ATE OF DEAT	ГН	REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE O	DAY	YEA	3. TIME OF DEATH
1	William B. Hewing 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (10)					, 1995	9:30 p. M
	214-18-1059 1 X M 2 🗆 F 76		F UNDER 1 YEAR IF UNDER ONTHS DAYS HOURS	MHN. 7. DATE O	9, 19	18 MG	RTHPLACE (State or Foreign writy) UTYLand
_	9a. FACILITY NAME (If not institution, give street and number)	9	b. CITY, TOWN OR LOCATE	ON OF OEATH	· 1	9c. COUNTY O	F DEATH
DIRECTOR	65 Lawrel Path Court RESIDENCE OF DECEDENT		Baltimore			Balt	imore
Ä	10a. STATE 10b. COUNTY	10c. CITY, 1	OWN OR LOCATION				10d. INSIDE CITY
	Maryland Baltimore	Bal	timore				1 TYES 2 NO
FUNERAL	65 Lawrel Path Court		10f. ZIP COD			U.S.A.	DF WHAT COUNTRY?
5	11. MARITAL STATUS 1 Naver Married 2 Married FORCES? 1 X YES	U.S. ARMED	13. WAS DECENDENT O	F HISPANIC ORIGIN?	(Specify Yes o	r No- 14. R	ACE — American Indian,
B	1 Naver Married 2 Married 3 Wildowed 4 Divorced FORCES? 1 X YES IF YES, GIVE WAR OR DAT WORLD WAY	ES	1 YES 2 NO	n, Mexican, Puarto Ri Specify:	can, etc.)		pochy: White
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S US	UAL OCCUPATION	16b. i	(IND OF BUSI	NESS/INDUSTR	Y
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)		k done during most at working tired.) etal Worker		eleph	one Co.	
Ö	17. FATHER'S NAME (First, Middle, Last)	-	18. MOT	HER'S NAME (First, Mi			
BE C	Alvin Hewing			izabeth (
5	190. INFORMANT'S NAME (Type/Print) Anna M. Hewing (Wife)		DRESS (Street and Number rel Path Co				21236
	20s METHOD OF DISPOSITION 1 Weurial 2 Cremation 3 Removal from State cogner	LACE AND DATE OF	pisposition (Name of Paith Cem.	DATE	20c. LOC	ATION — City or	r Town, State
	4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	villens of				umore,	, Maryland
	· Taket Modar		Schimunek 9705 Bela	Funeral ir Road.	Home Baltin	nore. N	ld. 21236
	23. PART I. Enter the disease, or complications that caused a shock, or heart failure. List only one cause on each	the death. Do not	enter the mode of dy	ing, auch aa cerdie	c or reepira	itory arrest,	Approximate
1	IMMEDIATE CALISE (Fine)	12.2	A-0				interval Between Onset and Daath
	disease or condition resulting in death)	CARCI	VOMA W	YIH ME	179179	1/1	
	DUE TO (OR AS A C	CONSEQUENCE OF):					
CERTIFICATION	Sequentially list conditions, DUE TO (OR AS A C	ONSEQUENCE OF):					
SAT	If any, leading to immediate cause. Enter UNDERLYING						į
Ė	CAUSE (Disease or injury that initiated events	CONSEQUENCE OF):					
ER	resulting in death) LAST						
	PART II. Other aignificant conditions contributing to death but	not resulting in t	the underlying ceuse (given in Part i.	4a. WAS AN A	UTOPSY 2	24b. WERE AUTOPSY FINDINGS
MEDICAL					PERFORM	ED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
					[YE\$ 2 [J NO	OF DEATH?
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	DEATH YES	□ NO □ UNC	ERTAIN 🗆			1 0 125 2 0 110
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26	B. PLACE OF DEATH	Check only one)				
YS!	1 YES 2 NO HOSPITAL:		THER:	sidence 6 🗆 Other (Specify)		
	27. MANNER OF DEATH 1 Natural 5 Pending 26e. DATE OF INJURY (Month, Day, Year)	26b. TIME O			RIBE HOW INJ	URY OCCURED	
D BY	2 Accident Investigation 3 Suicide 6 Could not be 26e. PLACE OF INJURY -	- At home, farm, stre			ION (Street and	d Number or Run	ral Route Number,
ш	4 Homicide determined building, etc. (Specify	"			Town, State)		
COMPLET	29s. CERTIFIER (Check only 1 CERTIFYINO PHYSICIAN: To the best of my knowled	ige, death occurred a	it the time, data and place,	and due to the cause	(a) and mann	er as stated.	
Š	one) MEDICAL EXAMINER: On the basis of examination a	and/or investigation, i	n my opinion, death occur	ed at the time, data a	nd place, and	dua to the caus	se(a) end manner as stated.
BE	296. BIGNATURE AND TITLE OF CERTIFIER	W		NSE NUMBER		29d. DATE SIGN	IED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEAT	W //TEM AT /	10/	112		- 71	0/7]
	Dr. Ted Paglinauan, Golden Ri	ng Medica	il Center,	8552 Phil	adelph	ia Rd.	Baltimore Md. 21237
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNAT	URE			-		
	FEB 1 5 1995 Stein Denison Rom	A STATE OF THE PARTY OF THE PAR					





HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the Manage of may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

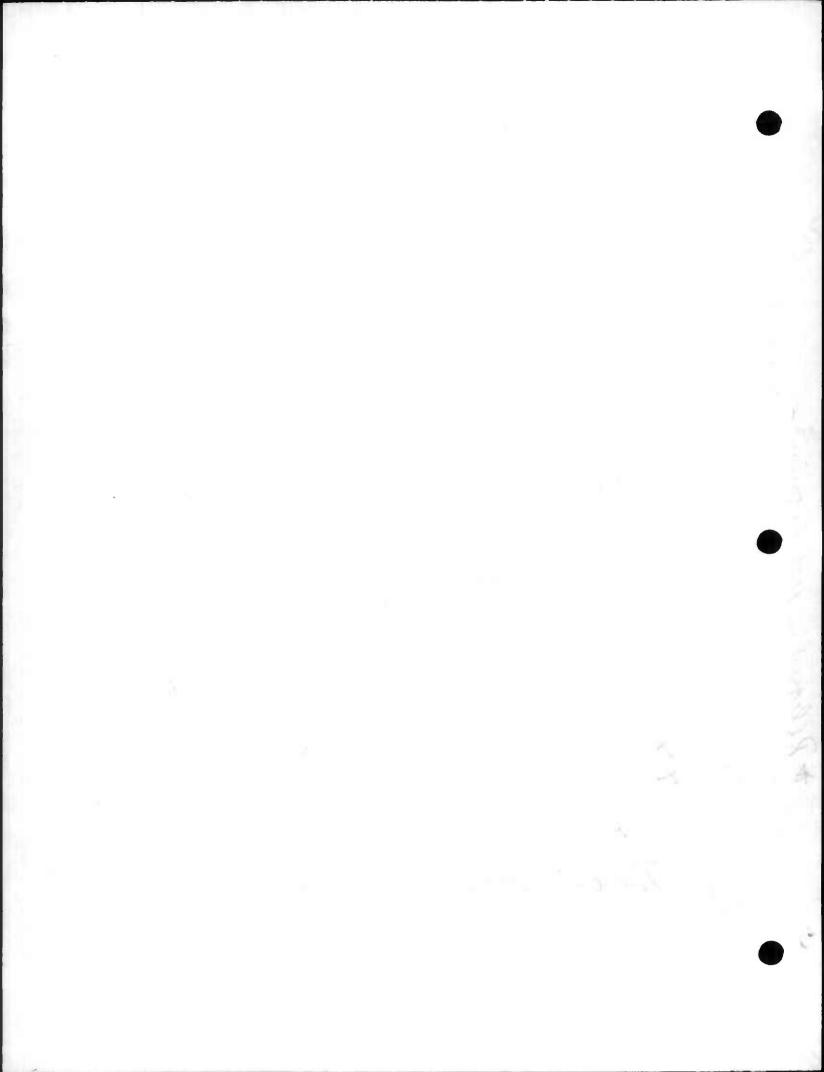
ANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. to the HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE,

1 - FOR STATE REGISTRAR

	REGISTRAR CERTIFICATE O	F DEATH	REG. NO.					
	1. Decedent's NAME (First, Middle, Last) Catherine E. Hilbinger		2. DATE OF DEATH DO FEBRUARY	12. 199	3. TIME OF DEATH 5 5:30 p. M			
	4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 X F 80 YRS. MONTHS DAY		7. DATE OF BIRTH Feb. 6, 19	0.00	ATTHPLACE (State or Foreign unity) Wyland			
TOR		N OR LOCATION OF DE		9c. COUNTY O				
E	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LO	CATION			104 INSIDE CITY			
L DIR	Maryland N/A Baltimore				10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
FUNERAL DIRECTOR	4238 Nicholas Avenue	21206		U.S.A	• WHAT COUNTRY?			
B	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES	Specify Cuban, Mexicent (ES 2 (A) NO Specify:	IC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	В	ACE — American Indian, lack, White, etc. Docity: White			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) N/A 180. DECEDENT'S USUAL OCCUPA (Give kind of work done during life. Do NOT use retired.) Homemaker	ATION most of working	Own Ho		,			
BE CON	17. FATHER'S NAME (First, Middle, Last) Gus Dennis		NE (First, Middle, Maiden					
TO B	190. INFORMANT'S NAME (TyperPrint)	et and Number or Rural R	Oute Number, City or Town	n, State, Zip Code)	21206			
	20b METHOD OF DISPOSITION 1 Burtel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)	(Neme of	DATE 20c. LOG	CATION - City or				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME SCHOOL 3331	and address of fac munek Fune	eral home ine, Balti					
	23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the r	mode of dying, euch	ea cerdiec or reepi	ratory arrest,	Approximeta			
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Jeu A5 CUD				Intervel Between Onsat and Death			
	DUE TO JOR AS A CONSEQUENCE OF):							
ON	Sequentially list conditions, If any, leading to immediate b. DUE TO (OM AS, A CONSEQUENCE OF):							
SAT	If any, leading to immediate cause. Enter UNDERLYING				i =			
CERTIFICATION	CAUSE (Disease Dr Injury that Initiated events resulting in deeth) LAST							
E I	d							
EDICAL		ing ceuse given in F	Part I. 24a. WAS AN PERFOR	MED?	4b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
ME	×			6	1 YES 2 NO			
Ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only on							
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only on EXAMINER?) 1 Aves 2 NO 1 Input lent 2 EX/Outpatient 3 DOA 4 Number Medical No. 1 Number Medical 1 Num							
¥ I	1 DAYES 2 NO 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing H	1	28d. DESCRIBE HOW IN	HIRY OCCURED				
ВУ Р		WORK? YES 2 NO	ave. Degombe from it	OCCURED				
	3 Suicide 8 Could not be building, etc. (Specify) 4 Homicide determined	fice	28f. LOCATION (Street at City or Town, State)	nd Number or Run	nl Route Number,			
COMPLET	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the lime, day one)				e(s) and manner as stated			
O BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUME			ED/(Month, Day/Year)			
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (HTEM 27) (Type, Print)	1001	- / /	- 4	21004			
	Dr. Theodore Niznik, 2801 Foster Ave., Patte	erson Park	Medical C	tr.Balt	21224 imore, Md.			
	31. DATE FILED (MONT) Day, Year) 324 REGISTRAR'S SIGNATURE							



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ВОХ
P.O.
RECORDS,
OF VITAL
DIVISION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician.

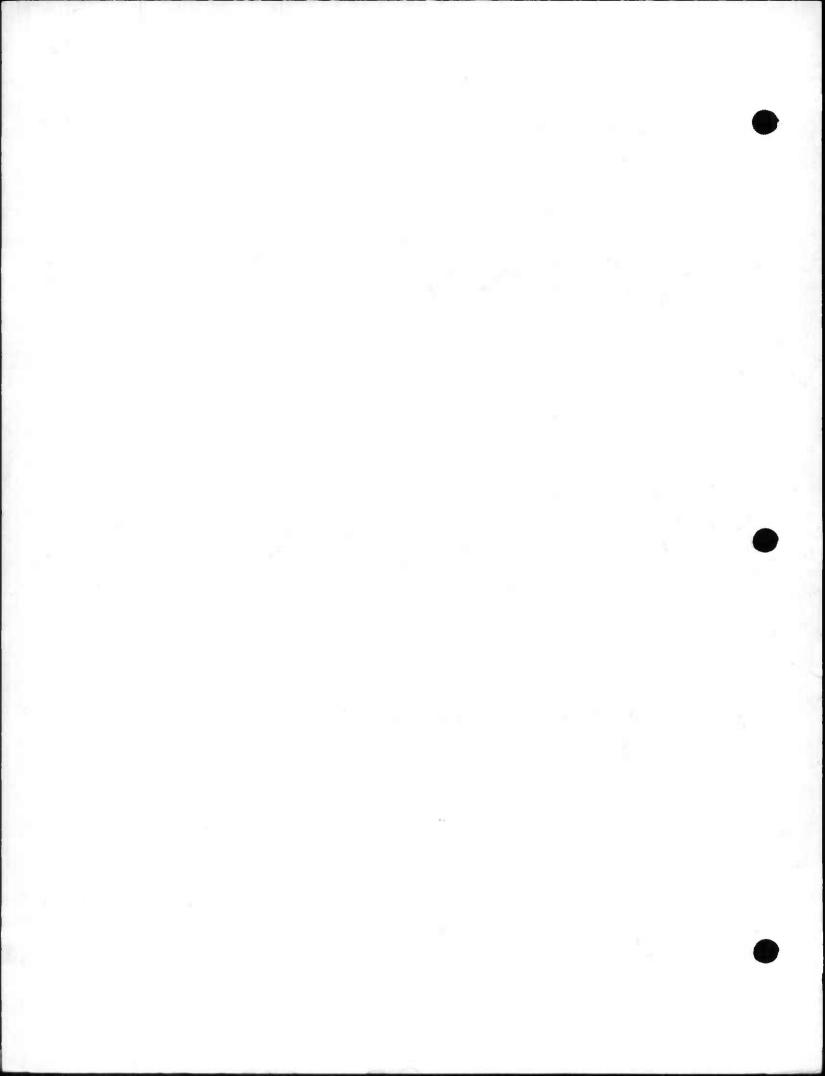
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	95 04525
	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
	REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) ROBERT CLARK HAGGERTY 2. DATE OF DEATH MONTH 2. DATE OF DEATH MONTH 2. DATE OF DEATH MONTH DECEDENT'S NAME (First, Middle, Last) ROBERT CLARK HAGGERTY DECEDENT'S NAME (First, Middle, Last) ROBERT CLARK HAGGERTY DECEDENT'S NAME (First, Middle, Last) REG. NO.
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (M. yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH (Mopth, Day Year) 1 0 M 2 F 70 YRS. MONTHS DAYS HOURS MIN. 3 6 2 4 4 Country) USA
TOR	90. FACILITY NAME (If not institution, give street and number) 7079 Augustine Herman Hwy RESIDENCE OF DECEDENT 90. COUNTY OF DEATH Cecil
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	7059 Augusture Heyman Hwy 21919
BY FU	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Married 2 Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- If yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, etc. 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- If yes, specify Cuban, Mexicen, Puerto Rican, atc.) 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- If yes, specify Cuban, Mexicen, Puerto Rican, atc.) 16. YES 2 Married 17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- If yes, specify Cuban, Mexicen, Puerto Rican, atc.) 18. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- If yes, specify Cuban, Mexicen, Puerto Rican, atc.)
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
	10 Farming 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname)
TO BE	Thomas Uhler Haggerty 190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD
•	Mrs Mary Haggerty 20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crematory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crematory or other place)
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE ROngold Wade, Dir 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD21201
/	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arreat, shock, or heart failure. List only one cause on each line.
	IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):
TION	Sequentially list conditions, if any, laading to immediate DUE TO (OR AS A CONSEQUENCE OF):
RTIFICATION	CAUSE (Disease or Injury that initiated eventa resulting in death) LAST
뜅	PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS
MEDICAL	PERFORMED? 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO
SICIAN: N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 28. PLACE OF DEATH (Check only one)
PHYSIC	ANNINER OF DEATH HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA Inpatient 3 DOA Inpatient 2 ER/Outpatient 3 DOA Inpatient 3
ВҰ	Netural 5 Pending Investigation (Month, Day, Year) INJURY MORK? Accident Investigation 25e PLACE OF INJURY At home form street fortons office 25t LOCATION (Street and Number of Purplement 100 Purplemen
ETED	4 Homicide determined building, atc. (Specify) City or Town, State)
COMPL	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner as stated. MEDICAL EXAMINER: On the beat of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) end menner ee stated.
TO BE (296. SIGNATURE AND TITLE OF CERTIFIER 290. DATE SIGNED (Month, Day, Your) 291. DATE SIGNED (Month, Day, Your) 292. LICENSE NUMBER 294. DATE SIGNED (Month, Day, Your)
-	Dr. Niel Taylor Northern Chesapeake Hospice Elkton, MD 21921

Northern Chesapeake

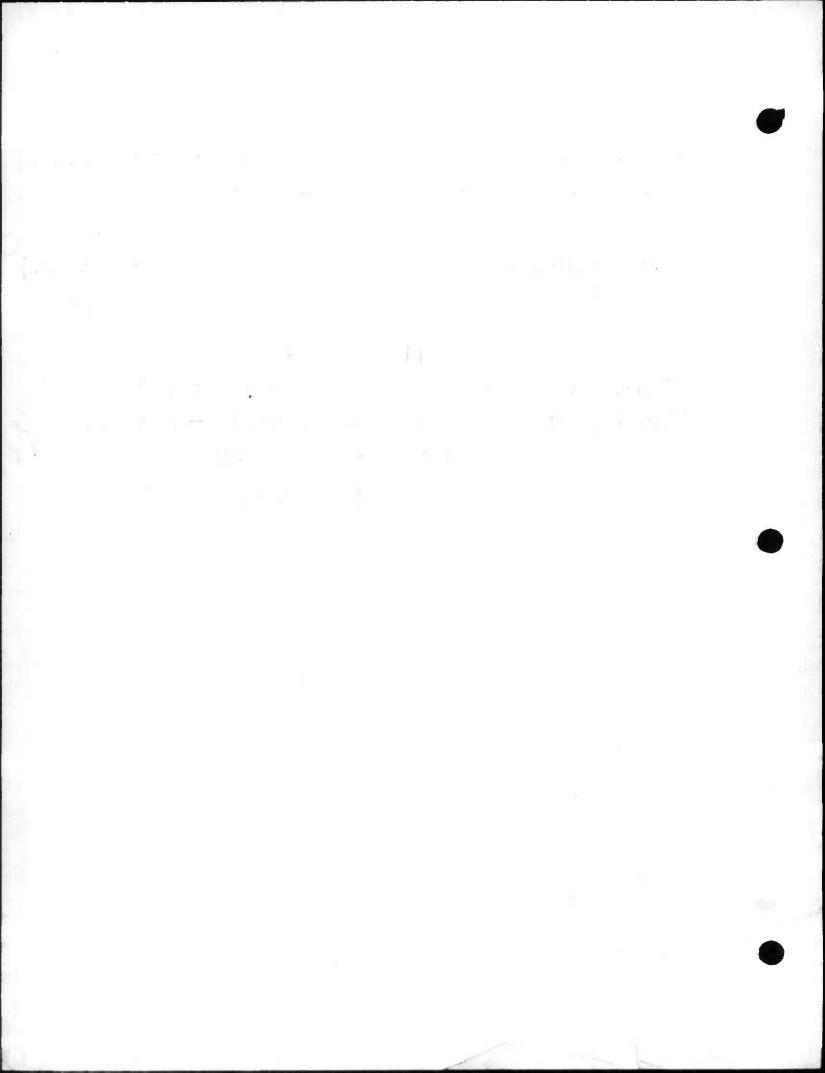
Dr. Niel Taylor 31. DATE FILE PER 2 1 15 1995



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		1 - FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTMENT CERTIFICATE	OF HEALTH AND	MENTAL HYGIE		
		1. DECEDENT'S NAME (First, Middle, Lest)	2500			2. DATE OF DEATH	DAY 9 5	3. TIME OF DEATH 3/64 N
9		1 000 -1115	5. SEX B. AGE (1)	fr yrs. last birthday) IF UNDER YRS. MONTHS	1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
2, 3 should	OB	JOHNS HOPKINS	Gentative		TOWN OR LOCATION OF D	EATH C	BC. COUNTY	OF DEATH J
₩.	DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY, TOWN O	OR LOCATION			10d. INSIDE CITY LIMITS?
it permit. Pages		10e. STREET AND NUMBER	- 12 h - 8 - 1	ART	101. ZIP CODE	19	10g. CITIZEN	OF WHAT COUNTRY?
020 physician. burlal-transit	FUNERAL	11. MARITAL STATUS 1 Never Married 2 Amerried	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	WAS DECENDENT OF HISPA If yes, specify Cuben, Mexico	in, Puerto Rican, atc.)	16 or No. 14.	On England RACE - American Indian, Black, White, atc.
21215-0020 al or attending physic for use as the burlat	ED BY	3 Widowed 4 Divorced 15. DECEDENT'S EDUCA		16a. DECEDENT'S USUAL OC	I YES 2 NO Specific		JSINESS/INDUST	specify: White
the hospital or a detached for us	COMPLET	(Specify only highest grade or Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind of work done of life, Do NOT use retired.)	auring most of working			
8 8 6 K	ш	17. FATHER'S NAME (First, Middle, Last)	Hai	r	18. MOTHER'S NA	ME (First, Middle, Maide	n Surname)	
be retained to ge 5 should e notified	TO B	Tracey 30	hason	19b. MAILING ADDRESS	Overla	Route Number, City or To	wn, State, Zip Coo	ue.
		4 Donation 5 Offier (Boach)	ceme	PLACE AND DATE OF DISPOSE etery, crematory or other place)		OATE 20c. L	OCATION — City	or Town, State
- · · ·		21. SIGNATURE OF FUHIMAL SERVICE LICE	ands	22.1	NAME AND ADDRESS OF FA	M/s I	A	10,101.0
in by remo		23. PART I. Enter the diseases, or co shock, or heart failure. Li	mplications that caused st only one cause on as	the death. Do not enter	tha mode of dying, auc	h as cardiac or read	piratory arrest,	Approximate Interval Between
d within 2: ho ompletely filled I, cremation, o		IMMEDIATE CAUSE (Finel disease or condition reaulting in death)	End Ste	DO COPD	¿ corp	rymona	le	Onset and Death
OX 6876 e be executed v sician and comp rrior to burial, c traumatic ev	CATION	Sequentielly list conditions, b.		CONSEQUENCE OF):	,			
O. BO) ertificate be ing physiciar giene prior other trau		If smy, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events		CONSEQUENCE OF):				
S, P. death c e attend fental Hy ury, or	CERTIFI	resulting in deeth) LAST						
y and the	MEDICAL	4	Xiety, A	it not resulting in the und	derlying cause given in	Part I. 24a. WAS AF PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
law law ept.		DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES N	O UNCERTAIN	v 🗆		1 YES 2 NO
DR ATTENDING PHYSICIAN: The Is DIRECTOR: After this certificate has bours after death with the State Da tem 28 is marked, or item 2	YSICIAN:	1 YES 2 NO	2 OSPITAL:	8. PLACE OF DEATH (Check of OTHER trient 3 DOA Nurs		6 ☐ Other (Specify)		
After this codeath with t	ВУ РНУ	27. MANNER OF DEATH Natural 5 Pending Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)	INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW	INJURY OCCURE	D
DIVISION DIRECTOR: After hours after death	ETED	3 Suicide 6 Could not be determined	28a. PLACE OF INJURY - building, atc. (Specif	— At home, farm, street, tacto	ry, offica	26t. LOCATION (Street City or Town, State	and Number or Ri)	Iral Route Number,
COSPITAL D ERAL DI MINT: If Ite	COMPLET	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	AN: To the best of my knowle On the basis of examination	edge, death occurred at the tir and/or investigation, in my op	me, data and place, and dua pinion, death occured at the	to the cause(a) and ma time, data and place, as	nner as stated. nd due to the cau	use(a) and menner as stated.
THE STATE OF THE S	O BE	29b. SIGNATURE AND TITLE OF CERTIFIER	7		29c. LICENSE NUM	IBER 3 & 3	29d. DATE SIG	NED (Month, Day, Year)
0	-	30. NAME AND ADDRESS OF ESTIGNI WHO	CUT IT A	TH (ITEM 27) (Type, Print)	5 Hepkins	Bay Vin	o circ	10
		FEB 1 5 1995 Fall	32. REGISTRAR'S SIGNA	TURE			-	
_		0		LOQ.	-			DUMM 40 D 410



3760. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a normal fired for may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 to fill the state Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.		3 should	
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the four after death. Page 6 may be retained by the hospit DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.		Pages 1, 2	
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the four after death. Page 6 may be retained by the hospit DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.		it permit.	
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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the four after death. Page 6 may be retained by the hospit DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	tending p	as the b	
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the four after death. Page 6 may be retained DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	pital or at	od for use	
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the four after death. Page 6 may be retained DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	the hosp	e detache	ì
OR ATTENDI DIRECTOR: A hours after d	etained by	(/S	
OR ATTENDI DIRECTOR: A hours after d	may be n	or, page 5	
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OR ATTENDI DIRECTOR: A hours after d	ž	ertificate I	**
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E FUN	SPITAL OR	VERAL DIF	** ** **
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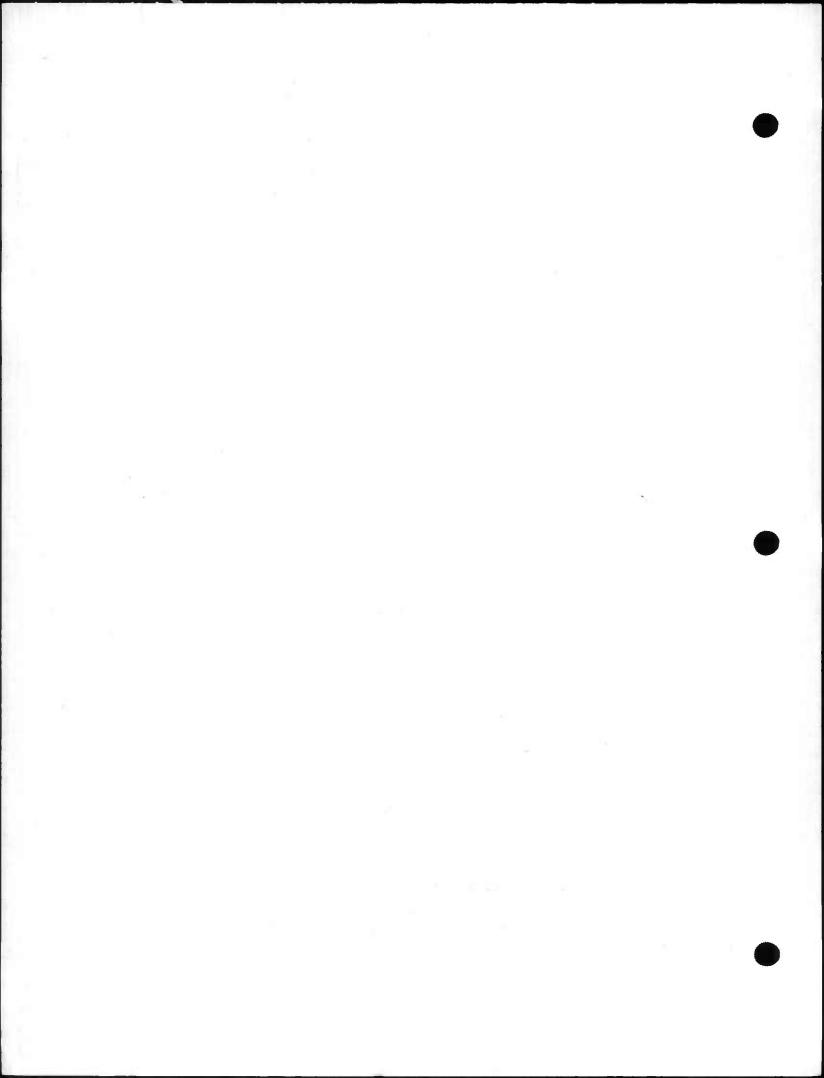
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	1 - STATE REGISTRAR	MAILI LAP		ICATE	OF DEA	TH	NIAL HYG			
	1. DECEDENT'S NAME (First, Middle, Last)	/				-9	DATE OF DEA		YEAR 3	. TIME OF DEATN
	C'mirles Jenk	we.	5			1	20	12	95	MA Clip
	4. SOCIAL SECURITY NUMBER 5. SEX		yrs. last birthday)	IF UNDER 1	YEAR IF UNDE	R 24 HRS. 7.	Month, Day, Ye	par) [] 9] 3	8. BIRTNPL Country)	ACE (State or Foreign
	217-09-9468 1xx 2 = F	81	YRS.		5.0					CAROL I NA
<u>ac</u>	9a. FACILITY NAME (If not institution, give street and number)	10145			OWN OR LOCAT			9c. CO	UNTY OF DEA	TN
5	LEVINDALE NURSING	HOME		B <i>P</i>	LTIMOR	_ (CITY		n/a	
DIRECTOR	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR	LOCATION				1	0d. INSIDE CITY LIMITS?
	MARYLAND n/a			B.A	LTIMOR			_	1	X YES 2 □ NO
RAI	10e. STREET AND NUMBER				10f. ZIP COD					AT COUNTRY?
FUNERAL	4208 FAIRVIEW AE. 11. MARITAL STATUS 12. WAS DECEDE	NT EVER IN II	S ADMED	1 12 WM	S DECENDENT	1216	ODIOWO (0I			STATES
	1 Never Married 2 Married FORCES?	1 YES	2V VNO	If y	ea, specify Cubi	n, Maxican, F	Puarto Rican, at	c.)	Black, 1	- American Indian, White, etc.
ВУ	3 Widowed 4 Divorced			'	YES 2 NO	Зрвспу.			Specify	BLACK
TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	-10	8a. DECEDENT'S (Give kind of	work done dur	JPATION ing most of worki	ng	16b. KIND O	F BUSINESS/IN	IDUSTRY	
COMPLET	Elementary/Secondary (0-12) Coilege (1-4 or 5	+)	iide. Do NOT u				DETH	венем	STEEL	
)MF	10 TH -		LABOR	KEK				ILEHEM	SIEEL	-
ECC	JOHN JENKINS				18. MOI	JENN	(First, Middle, M	laiden Surname)		
m	19a. INFORMANT'S NAME (Type/Print)		19b. MAJLING	ADDRESS (S	treet and Numbe			or Town, State, Z	ip Code)	
임	RitaRITZ M. HARRIS		4208		RVIEW		BALTI			21216
	20a. METNOD OF DISPOSITION 1 ☑ Purial 2 □ Cremation 3 □ Removal from State	20b. Pt	LACE AND DATE	OF DISPOSITI	ON (Name of		DATE 20	c. LOCATION -	- City or Town	, State
- 1	4 Doneston 6 Other (Samply) 21. SIGNATURE OF FUNERAL SPRINGE LICENSEE	- K	TNG M	The second name of the second				RANDAL	LSTOWN	N, MD
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	()	V0000	22, NA	ME AND ADDRE	SS OF FACILI	TY			
	1 threater.	10	Nes	WM.			11101			AVENUE
	23. FART I. Enter the diseases, or complications the shock or heert fallure. List only one ca	et vaused thused the	he deeth. Do i h iine.	not enter th	e mode of dy	ing, such e	s cardlec or	respiratory s	rrest,	Approximete Interval Between
				F "						Onset and Death
	resulting in desth)	Piro	L tory	tai	lure					
1_1		Men	1 . /	r):						
٥		OR AS A CO	ONSEQUENCE O	F):	1					1
CERTIFICATION	csuse. Enter UNDERLYING CAUSE (Disesse or Injury	rebra	BUSG	cula	r He	ide	ate			
	that initisted events DUE TO resulting in deeth) LAST	OR AS A CO	ONSEQUENCE O	F):						
馬	d									
	PART II. Other significent conditions contributing to	deeth but	not resulting	in the unde	rlying csuse	given in Par	rt I. 24a. W	AS AN AUTOPSY		ERE AUTOPSY FINDINGS
MEDICAL								ES 2 NO	C	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
W										YES 2 NO
Z	DID TOBACCO USE CONTRIBUTE TO CA					ERTAIN				
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		PLACE OF DEA	OTHER;	one)					
PHYSICIAN:	1 VES 2 NO 1 Inpatient 2 27. MANNER OF DEATH 28s. DATE O		ent 3 🗆 DOA		Nome 5 R		Other (Specify			
	1 Natural 5 Pending (Month,	Day, Year)		URY	WORK?		Id. DEŞCRIBE H	IOW INJURY OF	COMED	
D BY	2 Accident Investigation 3 Suicide 8 Could not be	OF INJURY -	At home, farm,			-	f. LOCATION (S	treet and Numbe	or Or Rural Rou	te Number.
F	4 Homicide determined	, etc. (Specify)					City or Town,	State)		
片	29a. CERTIFIER (Check only	t my knowledg	ga, death occum	d at the time	data and place	and due to t	the cause(a) and	d manner as str	ited.	
COMPLETE	one) 2 MEDICAL EXAMINER: On the basis of									nd manner as stated.
ш	296. SARNATARE AND TITLE OF CERTIFIER				29c. LIC	ENSE NUMBE	R	29d. DA	TE SIGNED (M	lonth, Day, Year)
OB	Allia /West rom	e	m		D	237	67	> K	Pla	W4 12 1795
Ĕ	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CALL	SE OF DEATH	(ITEM 27) (Type,		.1.1	Λ	6	7 1.	11	7,-11-10
	DEBLA WELTHENER 31. DATE FILED (Month, Day, Year) A2. REGISTR	24	34 W	Bel	ledere	HU	e., 5	a sto	119	21212
	31. DATE FILED (Month, Day, Year)	AR'S SIGNAT	Hola II				•)		
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	2.2.4		, ,							

31. DATE FILED (Month, Day, Year)
FEB 1 5 1995

		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPA CERTII	RTMENT OFICATE	F HEALTH AND OF DEATH	MENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Last) Sernand	BERNARD		`	CKSON	2. DATE OF DEATH 2	AT 6-95E	3. TIME OF DEATH 7.00 A M
pg.		4. SOCIAL SECURITY NUMBER 28-6782	1 M 2 🗆 F	yrs. lest birthday	MONTHS DA	YS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	2 8.8	Baltimere et lig
1, 2, 3 should	СТОВ	9a. FACILITY NAME (If not institution, give of BCCOWS) RESIDENCE OF DECEDENT	lospital.		Bb. CITY, TO	AN OR LOCATION OF D	EATN	Baff	imacely -
	DIREC	10e. STATE 10b. COUNT	Υ	10c. CI	TY, TOWN OR L	OCATION			10d. INSIDE CITY LIMITS?
permit. Pages		Maryland	na		Ва	ltimore			1 YES 2 NO
	ERAL	100. STREET AND NUMBER	044			101. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
A 13-00.00 attending physician. Se as the burial-transit	BY FUN	1 0 3 4 Calhou 11. MARITAL STATUS 1	N STICET 12. WAS DECEDENT EVER IN: FORCES? 1 ☐ YES IF YES, GIVE WAR OR DAT	2 NO	If ye	2 1 2 1 7 DECENDENT OF NISPA s, apocify Cuben, Maxico YES 2 NO Specification		N.C. C.	RACE — American Indian, Black, White, atc. Specify: Black
20 20	PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		16a. DECEDENT' (Give kind of life. Do NOT	work done durin	PATION g most of working	16b. KIND OF BU	SINESS/INDUST	RY
by the at on at on	E COMPL	17. FATNER'S NAME (First, Middle, Last)				16. MOTNER'S NA	AME (First, Middle, Maiden	Sumama)	
retained 5 should notified	TO BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADDRESS (St	eet and Number or Rural	Route Number, City or Tow	rn, State, Zip Code	(0)
Page 6 may be il director, page		20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Rem 4 Donation 6 Other (Specify) L. V.	ovel from State	PLACE AND DATE tery, crematory or D U QLX		N (Name of	DATE 20c. LC	CATION — City	or Town, State
death. Page 6 ma funeral director, p. J.		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE Ronald (wade, D	ir 22. NAN	E AND ADDRESS OF FA	more St, B	Anatom Balto,	y Board MD21201
filled in by the funera on, or removal.		23. PART I. Entar the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Finel	complications that caused List only one cause on each	the deeth. Do					Approximeta Interval Between Onset and Daath
ation at		disease or condition resulting in death)	eDUE TO (OR AS A (ONSEQUENCE	RS!	<u> </u>			
e be executed with sician and complet rior to burial, cren traumatic event	NO O	Sequentially list conditions,	b. DUE TO (OR AS A C	nduc	and	his			
certificate be (ding physician lygiene prior to	ERTIFICATION	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	c. DUE TO (OR AS A C	Inor 1	OFF.	Encephal	orathy		
L E E - 0	CERTI	that initiated eventa resulting in deeth) LAST	d				\		
that the ed by th and M	ΆŁ	PART II. Other significant condition	e contributing to deeth bu	t not reaulting	In the under	ying ceuse given in	Part I. 24a. WAS AN PERFOI	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
v red been t. of	N: MEDIC	DID TOBACCO USE (CONTRIBUTE TO C	AUSE OF	DEATH	YES NO			1 TES 2 NO
Hate H	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	B. PLACE OF DEATH (C)	heck only one)		
SICIAN: The certificate h the State 1, or item	≩	1 TYES 2 THO 27. MANNER OF DEATN	1 Impatient 2 ER/Outpat	tlent 3 DOA		Nome 5 Residence	6 Cher (Specify) 26d. DESCRIBE NOW	N ILIBY OCCUPE	10
PHY This will be will	ву Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Yeer)		JURY	WORK?	200. DESCRIBE NOW	NJOHT OCCORE	
TTENDI TTOR: A after de	ЕТЕР В	3 Suicide e Could not be datarmined	26a. PLACE OF INJURY – building, etc. (Specifi	At home, ferm,	street, factory,	office	261. LOCATION (Street City or Town, State)	and Number or Ri	ural Route Number,
TAL OR TAL OR 72 hour	COMPLE		CIAN: To the best of my knowle						
THE HOSPITAL THE FUNERAL filed within 72 i			R: On the basis of examination	and/or investigat	ion, in my opini				
O THE O THE e filed MPOR	BE	296. SIGNATURE AND TITLE OF CERTIFIES	Abboro	e M.	0	29c. LICENSE NUI		29d. DATE SIG	NED (Morith, Day, Year)

Bon Secorns Huspital



ours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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Item 23

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TO THE FUNERA
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IMPORTANT: II

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permit. Pages 1, 2, 3 should

signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit Health and Mental Hygiene prior to burial, cremation, or removal. DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within has been a Dept. of h this certificate his with the State [After after de DIRECTOR: hours FUNERAL WITHIN 72 H HOSPITAL

Item# 2.3. G-film 720 perF.H 2/17/95 P.C STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last 2. DATE OF DEAT 1995 YEAR Helen A. Kondilidis Feb. A SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. DAYE 1 M 27 YRS. Mar. 22, 888-30-9801 1943 W. Virginia 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Anne Arundel Medical Center Annapolis Anne Arundel RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1XXYES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3822 Leo Street 21226 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuben, Mexican, Puerio Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 TYES 2 NO Specify В 3 Widowed 4 N Divorced White COMPLETED 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 4 yrs. Waitress Restaurant 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Pete Meadows Mary Anne Novak BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Mary Kondilidis Leo Street Baltimore, MD 21226 20a. METHOD OF DISPOSITION

1 Durial 2 Cremation 3 Removal from State
4 Donation State (Specify Entombrent 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Moreland Memorial Park 2/18/95 Parkville, Maryland 21. SIGNATURE OF FUNERAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23. PART I. Entar the diseases, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or haart failure. List only one cause on each line, Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in dasth) DUE TO (OR AS A CONSEQUENÇE OF): mont CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, laading to immediate cause. Enter UNDERLYING 1.6 100 CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO OF DEATH? 1 TYES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER** HOSPITAL: OTHER 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Rasidence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED

Natural 1 YES 2 NO Arcident Investigation 28a. PLACE OF INJURY — At home, farm, street, factory, office building. atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 4 | Homicida 29a, CERTIFIER

1 XCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 MEDICAL EXAMINER: On the basis investigation, in my opinion, death occured at the time, data and placa, and due to the cause(a) and memor as stated.

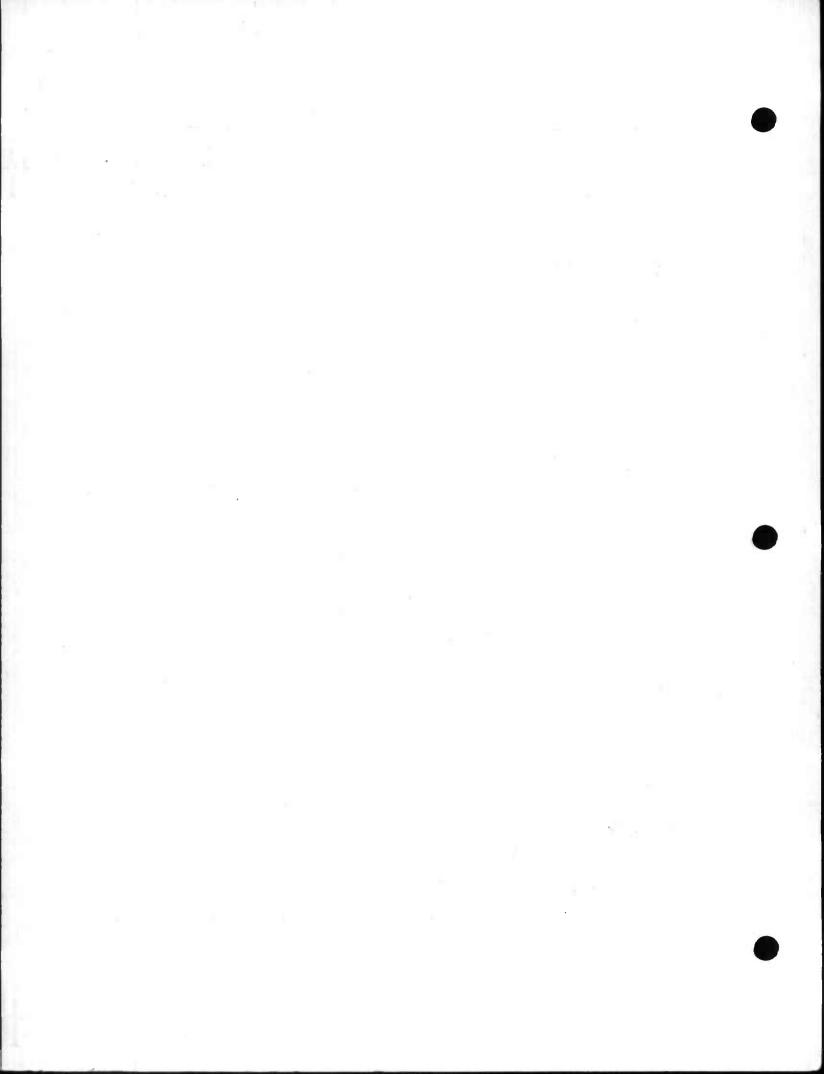
29c/DCENSE NUMBER 29d. DATE SIGNED (Month, Day,

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1600 Crain Hwy. Glen Burnie, MD 21061 Russell Suite 410

31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURE FEB 1995

CONLEWY



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	2. 3 should		
	Pages 1.		
0 THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	RECTOR: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ADDETANT: If from 28 to morked or them 22 shows any injury or other fraumotic awant the medical avantaged at any
OSPITAL	HE FUNERAL	ithin 72 h	ANT- 16 1
TO THE H	TO THE FI	be filed w	MADORE

	FOR 1 - STATE REGISTRAR		STATE OF I	MARYLAI	ND / DEP/					MENTAL	HYGIEN	_		
	F. DECEDENT'S NAME (FIRST	, Middle, Lash	us 1	onald	Carl	Kus S	Sr.			MONTH	of OEATH D	13.	YEAR 1995	3. TIME OF DEATH 2:00 a. M
	4. SOCIAL SECURITY NUMBER 2133445	33	5. SEX 1 X M 2 F	6. AGE (In	yrs. last birthda YRS	MONTHR	DAYS	IF UNDE	R 24 HRS. MIN.	7 DATE	OF BIRTH	1939	8, BIRTI	IPLACE (State or Foreign
	9a. FACILITY NAME (If not in	nstitution, give s	street and number)			9b. CIT	Y, TOWN	OR LOCAT	ION OF DE				NTY OF D	
DIRECTOR	Church Home		pital			E	Balti	imore	!			N/	A	
E S	10a. STATE	10b. COUNT	Y		10c. 0	HTY, TOWN	OR LOCA	TION						10d. INSIDE CITY LIMITS?
	Maryland	N/A			В	altim	ore							1 X YES 2 NO
FUNERAL	10e. STREET AND NUMBER						101	t. ZIP COC						WHAT COUNTRY?
N N	711 S. High	land A						212					S.A.	
	1 Never Married 2 🔀	Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE N	YES	2 XNO	13.	If yes, sp	ecify Cubi	nn, Mexica	in, Puerto F	? (Specify Yea lican, etc.)	or No—	14. RACI Blac	E — American Indian, k, White, atc.
B	3 Widowed 4 Divo	orced	IF YES, GIVE Y	MAN ON DAIL	ES		1 YES	2 💢 NO	Specify	у:			Spec	White
BE COMPLETED	15. DEC (Specify onl)	EOENT'S EDU y highest grade	CATION completed)	1	6a. OECEDENT	"S USUAL Cof work done	OCCUPATION OF THE PROPERTY OF	ON ost of worki	na	16b.	KINO OF BUS	SINESS/INI	DUSTRY	
Ë	Elementary/Secondary (CN/A		College (1-4 or 5	+)							1.			
MP	IV / A		N/A		кер	airma	ın						Wat	er & Sewage
S	Edward Kus	TOOK, LEST/								ME (First, N	liddle, Maiden	Surname)		
	19a. INFORMANT'S NAME (7	Type/Print)			19b. MAILI	NG ADDRES	S (Street a	_			er, City or Town	n. Stete 7h	2 Code)	
٤	Debra Kus (Wife)									Baltim			21224
10	20a. METHOD OF DISPOSIT	ION	oval from State	20b. P	LACE AND DAT	E OF DISPO	SITION /N	ame of		DATE	7	CATION -		own, Stata
	4 Donation 5 Other	(Specify)	76	_ Oak	Lawn					2/16/9	5 Ba	altim	nore,	Maryland
מעמייווופן ויוחאר	21. SIGNATURE OF FUNERA	L SERVICE LIC	CENSEE	1	//	22.		MUD A			1 Home			
DY DY	rota	J. K	SONOR	VI	1		3331	Bre	hms	Lane	, Balt	imor	e, M	d. 21213
	23. PART I. Enter the d ahock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eart fellure.	List only one can	L A	he death. Do h line.	l	the mo			h as cerd		ratory ar	reet,	Approximeta Interval Between Onset and Daath
CERTIFICATION	Sequentially list condit if any, leading to imme cause. Enter UNDERLY! CAUSE (Disease or injuthet initiated events resulting in deeth) LAS	diete ING Iry	/		ONSEQUENCE ONSEQUENCE			pres	n de	ay.	4 (7		
MEDICAL CI	PART II. Other algnifice	ent condition	na contributing to	death but	not resultin	g In the u	nderlyin	g ceuse	given in	Pert i.	24a. WAS AN PERFOR 1 YES 2	MEO?	246	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ä	DID TOBACCO U		RIBUTE TO CA	USE OF	DEATH '	∕ES □	NO [UNC	ERTAIN	V 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO	O MEOICAL	HOSPITAL:		PLACE OF O	OTHE	R:							
PHY	27. MANNER OF CEATH		28a. DATE OF	INJURY	28b. T	IME OF	28c. INJ	JURY AT	aaldence	8 Other	(Specify)	NJURY OC	CUREO	
ВУР		Pending Investigation	(Month, E	lay, Year)	'	NJURY M		YES 2	NO					
	3 Suicide 8	Could not be determined	28e. PLACE C building,	F INJURY — atc. (Specify)	At home, farm	, street, fac	tory, offic	1			TION (Street a or Town, State)	and Number	or Rural F	Route Number,
COMPLETED			CIAN: To the best of R: On the basis of e) and manner as stated.
TO BE C	29b. SIGNATURE	1/	MALICA	()	MO			29c LIC	Sense NUM	ABER 250)	29d. DAT	E SIGNED	(Month, pay, Year)
	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAU	SE OF DEATH	ALUM	oe, Print)	4	Ba	llen	we	,1	10	/	/
	21. DATE FILEO (Month, DATE	EB 1	5 1995 GISTR	ALDICA	tive of	arka								

OHMH-16 Rev 1/89

Albert

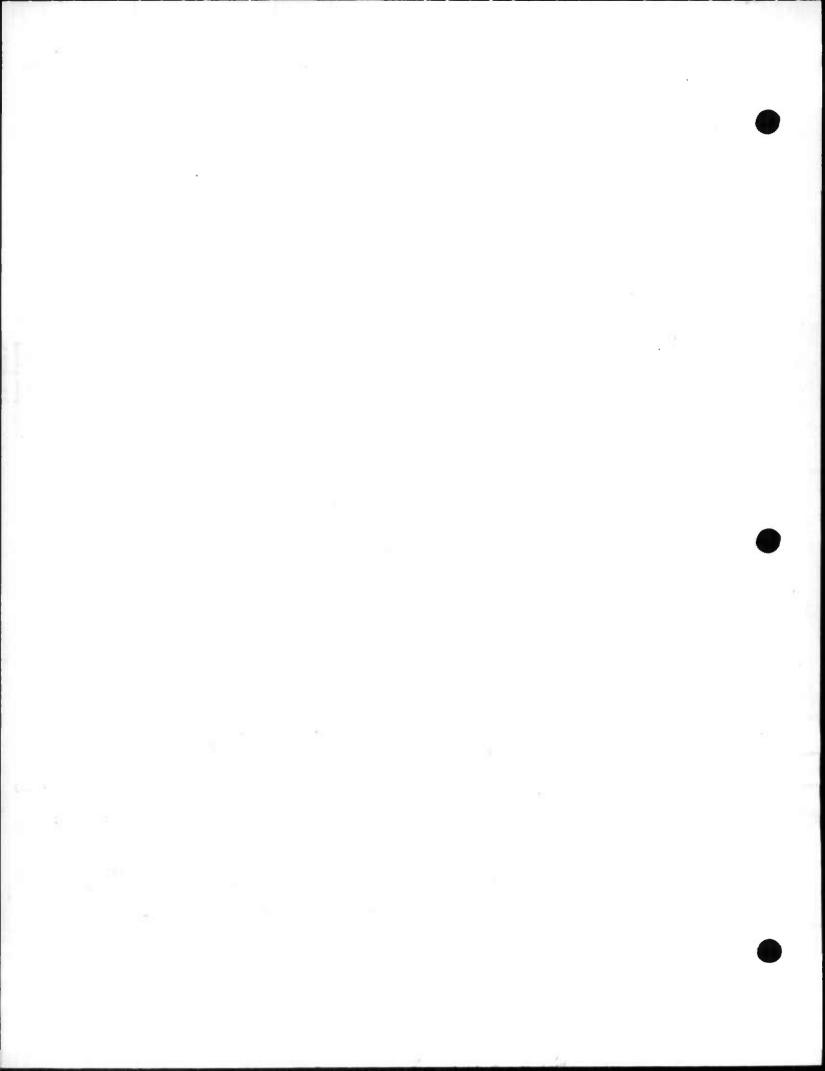
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1.2 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

" REGISTRAR	SIAIE UF MAKY	'LAND / DEPARTN CERTIFIC		EALTH AND MEN	NTAL HYGIEN	E	
1. DECEDENT'S NAME (First, Middle, Last)				2.1	DATE OF DEATH		3. TIME OF DEATH
Hedwig V.	KOTOWSKI				bruary 1		6:44 A. M
4. SOCIAL SECURITY NUMBER	The second second second		UNDER 1 YEAR	IF UNDER 24 HRS. 7. [DATE OF BIRTH	8. E	BIRTHPLACE (State or Foreign Country)
218-12-7153		70 YRS.		N	ov. 12,1		Maryland
9e. FACILITY NAME (ti not institution, give		96		OR LOCATION OF DEATH		9c. COUNTY	OF DEATH
Franklin Square				timore		Baltim	ore County
Monard 1 and 1		10c. CITY, TO	OWN OR LOCAT				10d. INSIDE CITY LIMITS?
Maryland I	Baltimore			imore			1 TYES 2 THO
8911 Carlisle A	Wanijo		101	21236		124	S.A.
11. MARITAL STATUS	12. WAS DECEDENT EVER	UNII S ARMED	13 WAS DEC	ENDENT OF HISPANIC O	DICINO (Casally Vac		RACE — American Indian,
1 Never Married 2 Married	FORCES? 1 YE	S 2 NO	If yes, sp	ecify Cuben, Mexicen, Pu 2 X NO Specify:	erto Rican, etc.)		Black, White, etc.
3 Widowed 4 Divorced	1 120, 6172 1011 011	- DAILE	1 123	2 kg NO Specify:			Specify: White
15. DECEDENT'S EDU (Specify only highest grad	ICATION e completed)	16a. DECEDENT'S USE (Give kind of work	done during mo	ON st of working	16b. KIND OF BUS	INESS/INDUST	RY
Elementary/Secondary (0-12) 10th grade	College (1-4 or 5+)	Ille. Do NOT use re	tired.)		_	**	
17. FATHER'S NAME (First, Middle, Last)		Homema	iker			Home	
Stephen Czyz				18. MOTHER'S NAME (F Josephin		Sumame) OWicz	
190. INFORMANT'S NAME (Type/Print)		105 MAILING AD	DDECC (Street o	nd Number or Rural Route			
Leo J. Kotowski	(husband)			le Avenue,			
20g, METHOD OF DISPOSITION	12	0b. PLACE AND DATE OF D			-7	CATION — City	
1 X Burlai 2 Cremetion 3 Ren 4 Donation 5 Other (Specify)	noval from State	emetery, crematory or other St. Joseph	s Ceme	1			, Maryland
21. SIGNATURE OF FUNERAL SERVICE LI			22. NAME AN	ID ADDRESS OF FACILITY	Y		, ridry raile
119	1/1		Schim	unek Funer	al Homes	, Inc.	
23. PART L Enter the diseases, or	complications that caus	ed the death. Do not		Belair Rd.			
ahock, or heart fallure.	List only one cause on	aach ilna.	aintai tiia iiio	ua or dynig, such as	cardiac or reapn	atory arrest,	interval Between
iMMEDIATE CAUSE (Final disease or condition	Composition						Onset and Death
resulting in death)							
		Heart Fai	lure	<u> </u>			years
	DUE TO (OR AS	A CONSEQUENCE OF):	lure				
Sequentially list conditions, if any, leading to immediate	b. Aoric Ster	A CONSEQUENCE OF):	lure				years years
If any, laading to immediata cause. Entar UNDERLYING CAUSE (Disease or injury	b. Aoric Ster DUE TO (OR AS	S A CONSEQUENCE OF): 10.5.1.S. S A CONSEQUENCE OF):	lure				
If any, leading to immediate cause. Enter UNDERLYING	b. Aoric Ster DUE TO (OR AS	S A CONSEQUENCE OF):	lure				
if any, laading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b. Aoric Ster DUE TO (OR AS	S A CONSEQUENCE OF): 10.5.1.S. S A CONSEQUENCE OF):	lure				
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If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition Gastrointesti DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 XNO 27. MANNER OF DEATH 1 Natural 5 Pending	DUE TO (OR AS a. AOric Ster DUE TO (OR AS d. DUE TO (OR AS d. BE CONTributing to death nal Bleeding RIBUTE TO CAUSE HOSPITAL: 1 Inperient 2 ERVOL 288. OATE OF INJURY (Month, Day, Year)	S A CONSEQUENCE OF): 10.S.I.S. S A CONSEQUENCE OF): S A CONSEQUENCE OF): but not resulting in the consequence of the consequ	he underlying NO Scheck only one) THER: Nursing Hom M 1 V	UNCERTAIN 5 G Residence 8 D JRY AT 28d ES 2 NO	PERFORI 1 YES 2	MED? NO NO	Vears 24b. Were autopsy findings AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition Gastrointesti DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 XNO 27. MANNER OF OEATH 1 Natural 5 Pending investigation 3 Suicide 8 Could not be datarmined 29s. CERTIFIER (Check only 1 CERTIFYING PHYS)	DUE TO (OR AS b. AOTIC Ster DUE TO (OR AS c. DUE TO (OR AS d	OF DEATH YES 28. PLACE OF OEATH (YES) 28. PLACE OF OEATH (YES) 28. PLACE OF OEATH (YES) 29. PLACE OF OEATH (YES) 29. TIME OF INJURY	he underlying Dheck only one) THER: Nursing Hom The 26c. INJ No M 1 7 R, factory, office	UNCERTAIN 5 G Residence 8 G DEPART 28d RR7 28d RR7 28d RR7 28f. 28f	PERFORM 1 YES 2 Other (Specify) OESCRIBE HOW IN LOCATION (Street e. City or Town, State)	MED? NO JURY OCCURE and Number or Ri ner se stated.	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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95

9c. COUNTY OF DEATH

UNITED

MEADE

E. NORTH

n/a

3. TIME OF DEATH

10d. INSIDE CITY

STATES

14. RACE — American Indian, Black, White, atc.

21215

AVENUE

Approximata

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 YES 2 NO

ebraary

interval Betwe

Onset and Death

1 YES 2 NO

BLACK

8. BIRTHPLACE (State or Foreign

EMPORIA.

10g. CITIZEN OF WHAT COUNTRY?

Specify:

4:20 PM

REG. NO.

2. DATE OF DEATH

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Lowery

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First_Middle, Last)

1 -

DYC February 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH MAR. 5, 1947 1 M 2 218-46-7050 47 permit. Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and no 9b. CITY, TOWN OR LOCATION OF DEATH HOSPITAL SINAI DIRECTOR BALTIMORE CITY RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION MARYLAND n/a BALTIMORE 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE CORDELIA 4821 21215 **AVENUE** funeral director, page 5 should be detached for use as the burial-transit retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2/7 NO IF YES, GIVE WAR OR DATES. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 TES 2 NO BY Specify: 3XXWidowed 4 Divorced 18e. DECEDENT'S USUAL OCCUPATION

"The bind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only h (Give kind of work done during ille. Do NOT use retired.) College (1-4 or 8+) YEARS LABORER FORT once. 17. FATNER'S NAME (First, Middle, Last. 18. MOTHER'S NAME (First, Middle Maiden Surname FENNER SAM FENNER 75 MABLE BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 **JERMAINE** LOWERY 4821 CORDELIA AVENUE, BALTIMORE, MD hours after death. Page 6 may be Pe 20a. METHOD OF DISPOSITION
1)(C)(Surfal 2 | Cremation 3 | 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - Cify or Town, State must DATE CROWNSVIII VΑ 4 Donation 6 Other (Specify) CEMETERY CROWNSVILLE. examiner 21. SIGNATURE OF PONEBAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 been signed by the attending physician and completely filled in by the r. of Health and Mental Hygiene prior to burial, cremation, or removal. the medical 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart fallure. List only one IMMEDIATE CAUSE (Final disease or condition_ Kespiratory duli requires that the death certificate be executed within resulting in death) event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF) SERIS traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate csuse. Enter UNDERLYING CAUSE (Disesse or Injury PERFORATED IGMOID COLON or other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST 10461 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? ASTHMA shows any 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN otinPHYSICIAN: OR ATTENDING PHYSICIAN: The law has b 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate I HOSPITAL: 1 TYES 2 OTHER: NO Nent 2 ER/Outpetlant 3 DOA 4 Nursing Home 8 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) marked, 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED DIRECTOR: After this of hours after death with Natural 5 Pending Investigation м 1 YES 2 NO ΒY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 60 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 28 4 Nomicide determined 29a. CERTIFIER CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. THE HOSPITAL ITHE FUNERAL ((Check only one) 2 MEDICAL EXAMINER: On the and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as 29c. LICENSE NUMBER 1201-KR9 296. SIGNATURE AND TITLE OF CERTIFIER BE 29d. DATE SIGNED (Month. Day Year) 20 5 30. NAME AND ADDRESS OF PERSON CAUSE OF DEATN (ITEM 27) (Type, Print) WHO COM KEITH ROBERTSON, SINAH 31. DATE FILED (Month, Day, Year)
FEB 15 1995 32. REGISTRAR'S SIGNATURE

whi develor Re

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DHMH-16 Rev 1/89

3. TIME OF DEATN

1050 York Road

04

1:45 A.M. M

77		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER	1 YEAR	IF UNDER 24	HRS. 7. DAT	E OF BIRTN		A. BIRTNPL	ACE (State or Foreign
		215200092	1 🗆 M 2 🕁 F	91	YRS.	MONTHS	DAYS		(Mo	nth, Day, Year)		Country)	
Pla		215-30-0983 9a. FACILITY NAME (If not institution, give s	Δ.	91						y 4, 19	_		land
3 should	œ					96. CITY	, TOWN C	R LOCATION	OF DEATN			TY OF DEAT	
	0	Manor Care Ruxt	on			Tow	son				Bal	timor	ce
, se	DIRECTOR	10a. STATE 10b. COUNTY	,		10c CIT	Y, TOWN C	OR LOCAT	HOM				140	d. INSIDE CITY
Page	<u> </u>												LIMITS?
mit		Maryland Balt	imore		C	ockey							YES 2 XNO
i Dec	A						101	. ZIP CODE			10g. CITIZI	EN OF WHA	T COUNTRY?
an.	Ä		m Circle					21030			U	.S.A.	
20 ysicit	FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN FORCES? 1	T EVER IN U.S.		13.	WAS DEC	ENDENT OF N	IISPANIC ORIG	IN? (Specify Yes	or No- 1	14. RACE Black, W	American Indian,
00 pd pd	ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W					2 NO :		ricelli, etc.)	- 1	Specify:	Title, etc.
215-0020 attending physician. ise as the burial-tran		41		100								Whit	e
.AND 21215-0020 the hospital or attending physician. detached for use as the burial-transit permit. Pages 1, 2, once.	COMPLETED	15. DECEDENT'S EDU- (Specify only highest grade	completed)	16a.	(Give kind of	work done i	CCUPATIO	oN st of working	16	b. KIND OF BU	SINESS/INDU	STRY	
AND 21 the hospital or detached for u	Ш	Elementary/Secondary (0-12)	College (1-4 or 5		Ille. Do NOT u					0 - 7			
N hosp	M M	10 yrs.			Home M	aker				Own F	iome		
MARYLAND retained by the hospit 5 should be detached notified at once.	8	17. FATNER'S NAME (First, Middle, Last)						18. MOTNER	'S NAME (First	Middle, Maiden	Sumame)		
d by d by	BE	John	Luby					Ros	se l	Bujanow	ski		
MARYL retained by 15 should be notified at	0	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	(Street a	nd Number or I	Rural Route Nu	mber, City or Tow	n, State, Zip C	Zode)	
	-	Mrs. Mary Calhou	n		Same	as i	#10						
ORE, 6 may be ctor, page	- 0	20a. METNOD OF DISPOSITION 12 Burlet 2 Cremation 3 Rem	mund from State	20b. PLA	CE AND DATE	OF DISPOS	ITION /Na	me of	DA	TE 20c. LO	CATION CI	Ify or Town,	State
OR e 6 ma ector, p		4 Donation 8 Other (Specify)	Over from State	Most.	Holy	ther place) Redee	emer	Cem.	2/13/9	5 Bal	timor	e, Ma	ryland
Pag Pag	- 1	21. SIGNATURE OF THE MAL SERVICE LIC	ENGEE /	/				O ADDRESS (
BALTIMORE, er death. Page 6 may be the funeral director, page ral.		·)= /	11	. ~	7	1 5	1	m-	-	7	_		0 York Roa
0 - 0	\rightarrow	Car o	· / an	49/		K	иск	Towson	n Fune:	ral Hon	ne, In	C. Tow	rson, M. 212
3 - 2		23. PART I. Enter the diseases, or of shock, or heart fellure.	List only one	me on each I	deeth. Do r Ine.	not snter	the mo-	de of dying,	auch ss ca	rdiac or reapi	iratory arre	st,	Approximate Interval Between
	1	IMMEDIATE CAUSE (Finel	1	noi		\sim 1	1 .				\		Onset and Death
		disease or condition resulting in death)	46	314ZA	31	CA	RC1	NOW	4 M#	ETAS	ATTIC	1	
ted within completely ial, cremati			DUE TO	(OR AS A CON	SEQUENCE O	F):			1				
GB760 executed will and comple o burial, cre	Z	Sequentieily list conditions,	b										
	CERTIFICATION	If any, leeding to immediate	DUE TO	(OR AS A CON	SEOUENCE O	F):							
BOX fificate be exphysician and prior to	2	CAUSE (Disease or Injury	c										
	1	that initiated events	DUE TO	(OR AS A CON	SEOUENCE O	F):							
O E E	H	resulting in death) LAST	d										
ORDS, P.O. that the death certified by the attending th and Mental Hygie any Injury, or other		PART II. Other aignificent condition	e contribution to	death but no	ot requition	In the un	dodulos	onine alve	n In Dark I	T			
- 2 A B -	MEDICAL		o contributing to	douth but he	A resulting	iii tile oii	werrynng	I cense give	en in Part I.	24a. WAS AN PERFOR		AM	RE AUTOPSY FINDINGS MLABLE PRIOR TO
Signed Health and www amp	ă									1 - YES 2	NO		MPLETION OF CAUSE DEATH?
w requires been sign of. of Heal												1[YES 2 NO
CS ept law	ä	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DI	EATH YE	S 🔲 1	40 P	UNCER	TAIN			-	
一年 書 書 書	5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. Pt	LACE OF DEAT								
F VITA SICIAN: The certificate to the State to the State to the State to	IS I	1 TYES 2 NO	1 Inpatient 2	ER/Outpatient	3 🗆 DOA	OTHER 4 Num	ing Nome	e 5 🗆 Reside	ence 8 🗆 Oth	ner (Specify)			
PHYSICIAN: this certifical with the St inked, or it	PHYSICIAN:	27. MANNER OF DEATN	28a. DATE OF (Month, D		28b. TIM	E OF	28c. INJI		28d. DI	ESCRIBE NOW I	NJURY OCCU	RED	
NG PHYS NG PHYS fer this eath with	BY	1 V Natural 5 Pending 2 Accident Investigation				М	1 🗌 Y	ES 2 N	0				
NOING MDING After r death		3 Suicide 8 Could not be	28a. PLACE O	F INJURY At	home, farm,	etreet, facto	ory, office		28f. LO	CATION (Street of yor Town, State)	and Number or	r Rural Route	Number,
ATTENDING STOR: After after death	ETE	4 Nomicide determined		(Cat.	y or rown, state)			
DIVISION POS ATTENDING F DEETIDE: After Nove after death Herr 28 is man	뿌	298. CERTIFIER 1 CERTIFYING PNYSI	CIAN: To the best of	my knowledge	death occurs	ad at the ti	me date	and place, an	d due to the e	aussis) and mar			
E 20m	COMPL	2 MEDICAL EXAMINE											d manner on etaled
TO THE COSP. TO THE POETS De filed with							,			Prace, all			
불분들	BE	296. SIGNATURE AND TITLE OF CENTIFIES	1). []	1				29c. LICENSI	E NUMBER		29d. DATE	SIGNED (M	Ome war
222	2	July 1	10					115	1821		-4	12	10
2	٦	30. NAME AND ADDRESS OF PERSON WA	COMPLETED CAN	SE OF DEATH (I					v2 -	2-0		- 33	(445)
10	- 1	STOP DOF	IN-	[1]	740	11 Q	JUE	KV	1< >(JIIEL	JZ I	Q. Bi	MMI)

Landers

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

Mary

4. SOCIAL SECURITY NUMBER

1. DECEDENT'S NAME (First, Middle, Last)

M

95 04533

2. DATE OF DEATH

February 11,1995

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE

1. DECEDENT'S NAME (First, Middle, I							REG. NO.			
	.mst)						OF DEATH			3. TIME OF DEATH
Pauline		T. i	tch	field		MONT	н м eb 12		YEAR	0815
4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. lest	birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE	OF BUREL		8. BIRTH	IPLACE (State or Foreign
212-22-0508	1 🗆 M 2 💢 F	76	YRS.	MONTHS DAYS	HOURS MIN.	Jan.	h, Day, Year)	19	Count	ryland
9a. FACILITY NAME (If not institution,	give street and number)			96. CITY, TOWN	OR LOCATION OF D			9c. COUN		
3767 Ravenu	ood Avenue	2		Bal	timore				N/	A
RESIDENCE OF DECEDEN			40. 000							
3767 Ravenu RESIDENCE OF DECEDENT 10a. STATE 10b. CO Maryland	N/A	1	10c. CTTY	TOWN OR LOCA						104. INSIDE CITY LIMITS?
100. STREET AND NUMBER	N/A		L	Balti						1 X YES 2 NO
10e. STREET AND NUMBER 3767 Ravenwood 11. MARITAL STATUS 1 Never Merried 2 Merried 3 X Wildowed 4 Divorced	Avenue			10	f. ZIP CODE 2221:	3 — ²¹	213			· A.
11. MARITAL STATUS	12. WAS DECEDENT E FORCES? 1	VER IN U.S. ARI	MED		CENDENT OF HISPAI			or No-	14. RACE	- American Indian, c, White, atc.
	IF YES, OIVE WAR	OR DATES			secify Cuben, Mexico 2 X NO Specif		ricen, etc.)		Speci	
15. DECEDENT'S (Specify only highest	EDUCATION	16a. DEG	CEDENT'S	SUAL OCCUPATI	ON	166	. KIND OF BUS	INESS/IND	JSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT use	ork done during m retired.)	ost of working					
N/A	N/A	Fa	ctor	Worke	r	An	nericar	Banl	c St	ationary
15. DECEDENT'S (Specify only highest to the secondary (0-12) N/A 17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First,	Middle, Maiden	Sumame)		
Stanley Guszak					Ros	se St	ys			
19a, INFORMANT'S NAME (Type/Print)		196	. MAILINO	ADDRESS (Street	end Number or Rural	Route Num	ber, City or Town	n, State, Zip	Code)	
Henry Guszak (B	rother)	R	. R.	#1, Bo	x 105, Sh	nicks	shinny,	Pa.	186	55
20a, METHOD OF DISPOSITION 1 Z. Burlel 2 Cremation 3	Removal from State			DISPOSITION (N		OAT	E 20c. LO	CATION — C	ity or To	wn, State
4 Donetion 6 Other (Specify)		Parky Parky	or other or other or other other or oth	_{er place)} Cemeter	У	1/1	15 Ba	altim	ore,	wn, State Maryland
21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE				ND ADDRESS OF FA	CILITY	**			
11/1/65	4			1	munek Fur Brehms 1				W.I	21212
23. PART I. Enter the diseases, shock, or heart falls IMMEDIATE CAUSE (Finel	ure. List Dnly ons cause	on each line.								Approximata interval Between Onset and Death
disease or condition	· Alkero	colore	phic	Cur	dious	will	ur	013-	196	2
resulting in death)	DUE TO COR	AS A CONSES	HENOE OF	-0-1		1000			- 1	1
	DUE TO (OF	R AS A CONSEO	UENCE OF	:				_		1
	DUE TO (OR	R AS A CONSEO	UENCE OF)	:						
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Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant cond DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAE EXAMINER? 1 Netural 5 Pending Investiget 2 Accident 3 Suicide 6 Could not determine 29e. CERTIFIER Check only One) 2 MEDICAL EXAMINER 29b. SIGNATURE ANO TITLE OF CERTIFIER 29b. SIGNATURE ANO TITLE OF CERTIFIER	DUE TO (OR oUE TO (OR d. DUE TO (OR d. NTRIBUTE TO CAUS L HOSPITAL: 1 Inpetent 2 ER 28e. DATE OF INJ (Month, Day, 1) be d HYSICIAN: To the best of my MINER: On the basic of exemit	R AS A CONSEO R AS A	UENCE OF)	the underlyin Check only one Check	g cause given in UNCERTAIN SE Rasidence UNCERTAIN REST OF RESIDENCE UNITY AT PYES 2 NO a end place, and due leath occured at the 29c. LICENSE NUM C C	Pert I. 6 Othe 26d. DES 281. LOC City fo the cautime, date	24a, WAS AN. PERFOR 1 YES 2 ((Specify) CRIBE HOW IN ATION (Street a or Town, State)	AUTOPSY MED? JURY OCCU and Number of mer ee stated dum to the 29d, DATE	24b. 24b. 24b. Aural R d. ceuse(e)	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO Oute Number, and manner as stated. (Month, Day, Year)

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	1 - FOR STATE REGISTRAR	STATE OF MARYLANI	D / DEPART	MENT OF	HEALTH AND	MENTAL HYGIE			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF D	EATH
	ENA Propst	LEWIS					8. 199	5 2205	рм
				F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8	BIRTHPLACE (State of	
			00 YRS.	ONTHS DAYS	HOURS MIN.	4-29-18	94 W	est Vira	inia
	9e. FACILITY NAME (If not institution, give stree		5	b. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUNT	Y OF OEATH	
CTOR	Sacred Heart H	lospital		Cumb	erland		All	egany Co	
딥	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c CITY	TOWN OR LOC	TION			10d. INSIDE C	174
DIRE	westvirginia ·	Mineral Co	10		Ashby			LIMITS?	
RAL					of, ZIP CODE		100 CITIZE	1 TYES 2	
1 101	Dawnview Mano	PO BOX 68				26719		USA	
FUNI	11. MARITAL STATUS	2. WAS DECEOENT EVER IN U.S		13. WAS DE		NIC ORIGIN? (Specify Y	8 or No — 14	I. RACE — American I	ndien.
- 1	1 Never Merried 2 Merried	FORCES? 1 YES 2		If yes, s		en, Puerto Ricen, etc.)		Black, White, atc.	
D BY	3 🔀 Widowed 4 🗌 Divorced					···		specify: Whit	e
ш	15. OECEDENT'S EDUCAT (Specify only highest grade cor	ION 16e npleted)	Give kind of wor	k done during n	ION lost of working	16b. KIND OF B	JSINESS/INOUS	STRY	
Ē	Elementary/Secondary (0-12)	College (1-4 or 5+)	Iffe. Do NOT use i	•	la a 4				
Once.			Textil	e wor					
	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Maide	n Surname)		
B B	19a. INFORMANT'S NAME (Type/Print)						_		
TO BE	Robert A. Lewi	,				Route Number, City or To		753	
a a	20e. METHOD OF DISPOSITION								
nust	1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramova 4 🕅 Donailon 5 ☐ Other (Specify)		CEAND DATE OF c, cremetory or othe		lame of	DATE 20c. L	OCATION — CIT	y or Town, State	
Je Je	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEER onald Was	le. Dir.	22. NAME /	AND ADDRESS OF FA	ACILITY			
Ea	1 20 BOX	2 /	,			STATE		OMY BOAR	
8	wan w. fan	Sarry				imore St			1
medical examiner must be	23. PART I. Enter the diseases, or con ahock, or heart failure. Lia	iplications that caused the t only one cause on each	e death. Do not line.	enter the m	ode of dying, suc	ch as cardiac or rea	oiratory arrea		imata Between
e e	IMMEDIATE CAUSE (Final		_						nd Death
=	reaulting in death)								lays
other traumatic event, the TIFICATION		DUE TO (OR AS A COM		210	10.0)	M	4 -
o late	Sequentially list conditions, Due to (or as a consequence of): Output Due to (or as a consequence of):								
AT	If any, leading to immediate cause. Entar UNDERLYING								
FI	CAUSE (Disease or Injury that initiated eventa DUE TO (OR AS A CONSEQUENCE OF):								
ry, or other traumatic	reaulting in death) LAST								
****	DADT II OIL								
	PART II. Other algoriticant conditions of		ot resulting in	the underlyli	ng cause given in	Part I. 24s. WAS A	N AUTOPSY RMED?	24b. WERE AUTOPS	OR TO
EDIC/	- PNEUM	DNIM				1 _ YES	2 NO	COMPLETION OF DEATH?	F CAUSE
2 2							•	1 [YES 2)	NO
ed, or item 23 s PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NOW UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
		OSPITAL:	0	(Check only one THER:)				
17S	1 YES 2 NO 1	28e. DATE OF INJURY				6 Other (Specify)			
By By	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME O	Y W	JURY AT ORK?	26d, DESCRIBE HOW	INJURY OCCUP	RED	
	2 Accident Investigation	26e. PLACE OF INJURY — A	t hame from etc.		YES 2 NO				
Z8 IS TED	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)	t nome, jarm, stre	et, ractory, om	Ce	261. LOCATION (Street City or Town, State	and Number or)	Rural Route Number,	
	On APPOVIED								
COMPL	(Check only 1 CENTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner as stated.								
O BE COMPLE	2 MEDICAL EXAMINER: On the besis of axamination end/or investigation, in my opinion, death occured at the time, data end place, end due to the cause(s) end manner es stated						s stated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIER	1 - 1	٥				29d. DATE S	DATE SIGNED (Month, Day, Year)	
<u>₹</u>	rame J'an	versood m.	υ	-	D23774 > February			wary 9,	1995
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								
	DR. PAUL LIVENGOOD 31. DATE FILEO (Month, Day, Year)	, M.D., 912 S		TARY C	UMBERLAN	D, MD 2150	02		
	FEB 1 5 1995	Julia & Tamban							
1 1	1 FD 4 0 1000	I was a diametron	Mardelle						

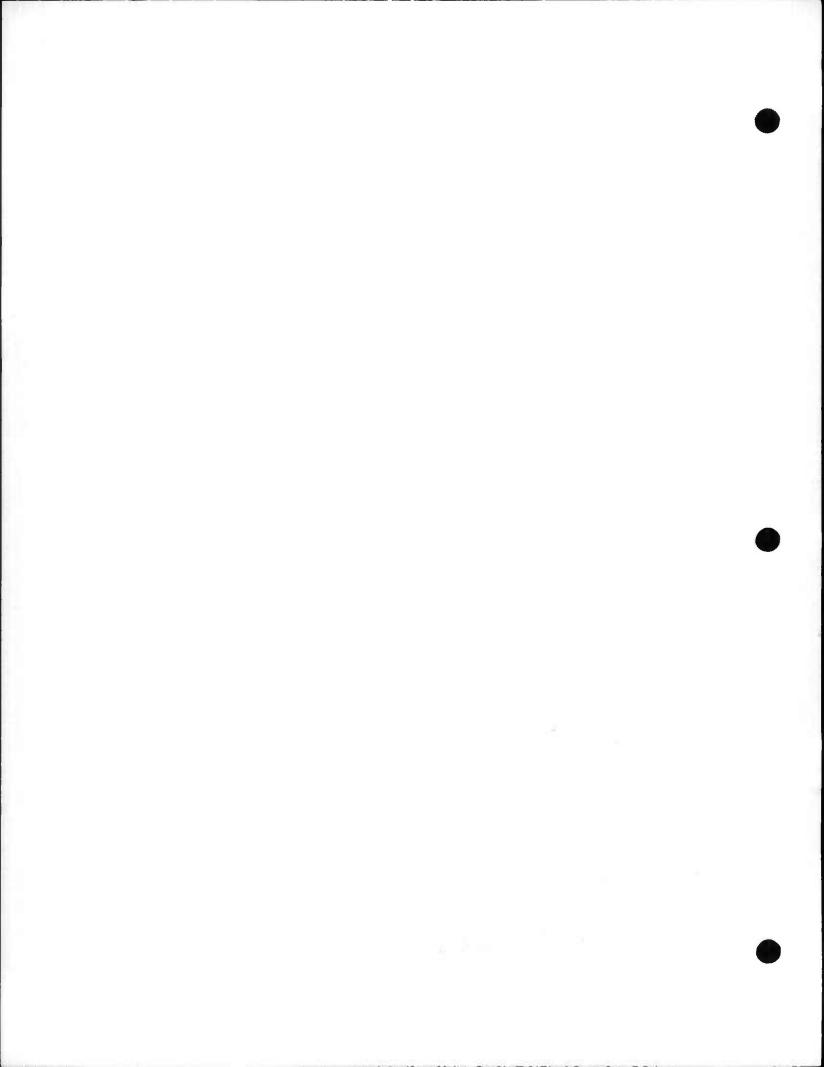
SALTIMORE, MARYLAND 21215-0020 r death. Page 6 may be retained by the hospital or attending physician. In funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should	-0020	ing physician,	the bunal-transit permit. Pages 1, 2, 3 should
ALT death.	IMORE, MARYLAND 2121	Page 6 may be retained by the hospital or atter	director, page 5 should be detached for use a
	MALT	death.	e funeral

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLET	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: If Nem 28 is marked, or Nem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
he funeral director, page 5 should be detached for us ral,	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, crematon, or removal,
or death, Page 6 may be retained by the hospital or	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within to reform after death, Page 6 may be retained by the hospital or recovery

	1 - FOR STATE REGISTRAR	STATE OF MARY		ENT OF HEALTH AND TE OF DEATH	MENTAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Les Wanda	Denise	Moor				3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 219-66-5114 98. FACILITY NAME (If not institution, give	1 🗆 M 2 🔀 F	41 YRS. MONT	NDER 1 YEAR IF UNDER 24 HRS. HS DAYS HOURS MIN. CITY, TOWN OR LOCATION OF 1	7. DATE OF BIRTH (Month, Day, Year) Sep. 20,	8. BIRTI Count	vland	
TOR	1761 Gorsuch Avenue			altimore		N/A		
DIRECTOR	10a. STATE 10b. COU			VN OR LOCATION		 	10d. INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER	I/A	Dd.	101. ZIP CODE		10g. CITIZEN OF	1 ∑ YES 2 □ NO WHAT COUNTRY?	
FUNERAL	1761 Gorsuch Ave	PNUE	R IN II S ARMED	21218	ANC ORIONIS (Sec. 1/4. V.	U.S.A		
B	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 Y	S 2 NO	It yes, specify Cuben, Mexic 1 YES 2 NO Specific No.	en, Pueño Rican, etc.)	or No 14. RAC Blac Spec	E Americen Indien, k, White, atc. #y: Black	
COMPLETED	15. DECEDENT'S E (Specify only highest gra Elementary/Secondary (0-12)	DUCATION side completed) College (1-4 or 5+)	16a. DECEDENT'S USUA (Give kind of work of life. Do NOT use retin	one during most of working	16b. KIND OF BUS	HNESS/INDUSTRY	DIGON	
MP	12th 17. FATHER'S NAME (First, Middle, Last)	N/A	N/A		N/A			
	William E. Moore	2			ame (First, Middle, Maiden e Mae Jorda			
TO BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDR	IESS (Street and Number or Rura				
٦	Johnnie Mae Will			such Avenue/	Baltimore,	MD 21218		
	20e. METHOD OF DISPOSITION 1 Suriel 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	emetery, crematory or other pla	ice)		CATION City or To		
	21. SIGNATURE OF UNERAL SERVICE		Druid Ridge	22. NAME AND ADDRESS OF F March Funeral 1101 E. North	Home East	esville,		
	23. PART i. Enter the diseases, o	r complicetions that cou	ed the deeth. Do not ar				Approximate	
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	e. List only one cause or	each lina.				Interval Between Onset and Death	
	Sequentially list conditions, if any, leading to immediate Direct Progression Density of Constant of Sequence of: Direct Progression Density of Sequence of Sequ						CV	
CERTIFICATION	cause. Enter UNDERLYING						> teyes	
ERTIFI	CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):							
AL C	PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FIND						. WERE AUTOPSY FINDINGS	
PHYSICIAN: MEDIC	MAGNIC MARKETITIS C					AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
Σ.	DID TOBACCO USE CON	ITRIBUTE TO CAUSE	OF DEATH YES	NO UNCERTA	NΠ		1 NES 2 NO	
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:							
I X	1 VES 2 NO	1 Inpatient 2 ER/O	utpetient 3 DOA 4 D	Nursing Home 5 Aesidence				
BY P	1 Natural 5 Pending 2 Accident Investigation) INJURY	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW IN			
	3 Suicide 8 Could not b 4 Homicide determined	building, etc. (S	RY At home, farm, street, pecify)	— At home, farm, street, fectory, office 28t. LOCA City o			OCATION (Street and Number or Rural Route Number, ty or Town, State)	
COMPLETED	29e. CERTIFIER (Check only one) 1							
H H	296. SIGNATURE AND TITLE OF CERTIFI	IER .		29c. LICENSE NU	MBER	29d. DATE SIGNED	(Month, Day, Year)	
w 11	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 2			DOG966 ► 2/14/95				
2	30. NAME AND ADDRESS OF PERSON V	VHO COMPLETED CAUSE OF	DEATH (ITEM 27) (Type, Print)					
0	30. NAME AND ADDRESS OF PERSON & Research Lent 31. DATE FILEO (Month, Day, Year)	VHO COMPLETED CAUSE OF W// / / / / / / / / / / / / / / / / /	1 N. Cat	hoderals.	t. Bultin	oul, MI	121201	



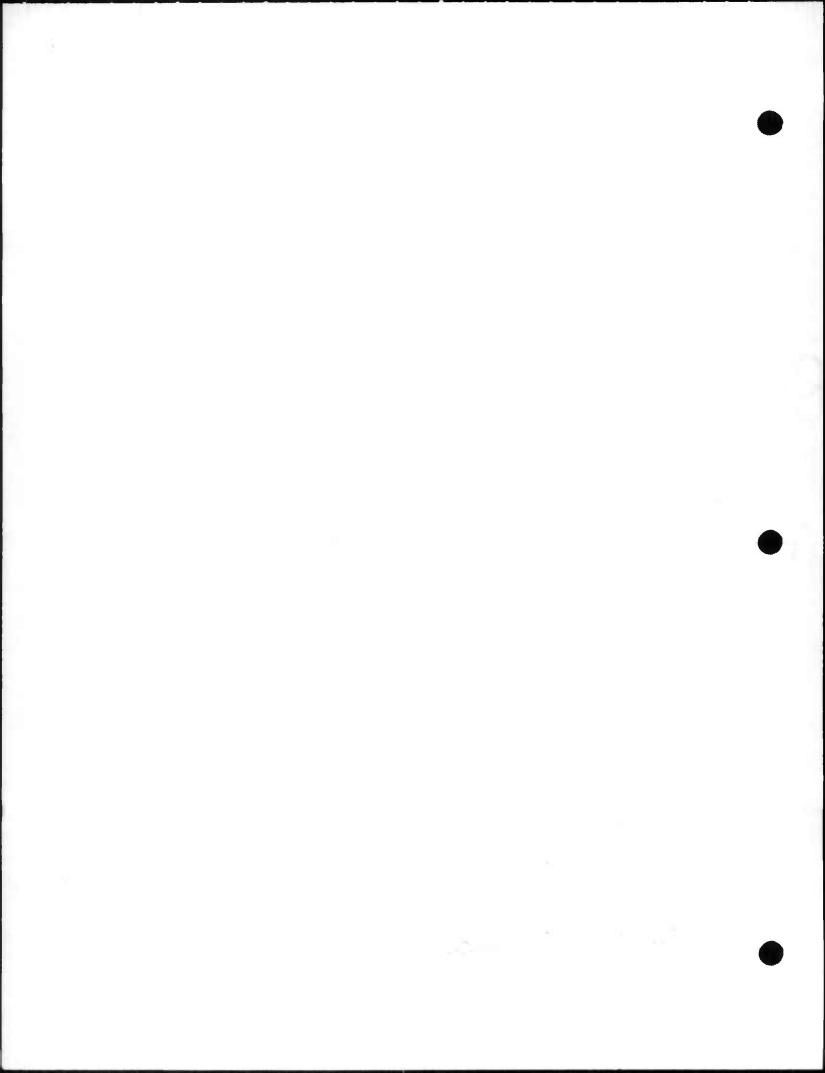


		the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
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BALTIMORE, MARYLAND 21215-0020	er death. Page 6 may be retained by the hospital or attending physician.	detached for use as the
MARYL	retained by t	5 should be
ALTIMORE,	death. Page 6 may be	funeral director, page
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

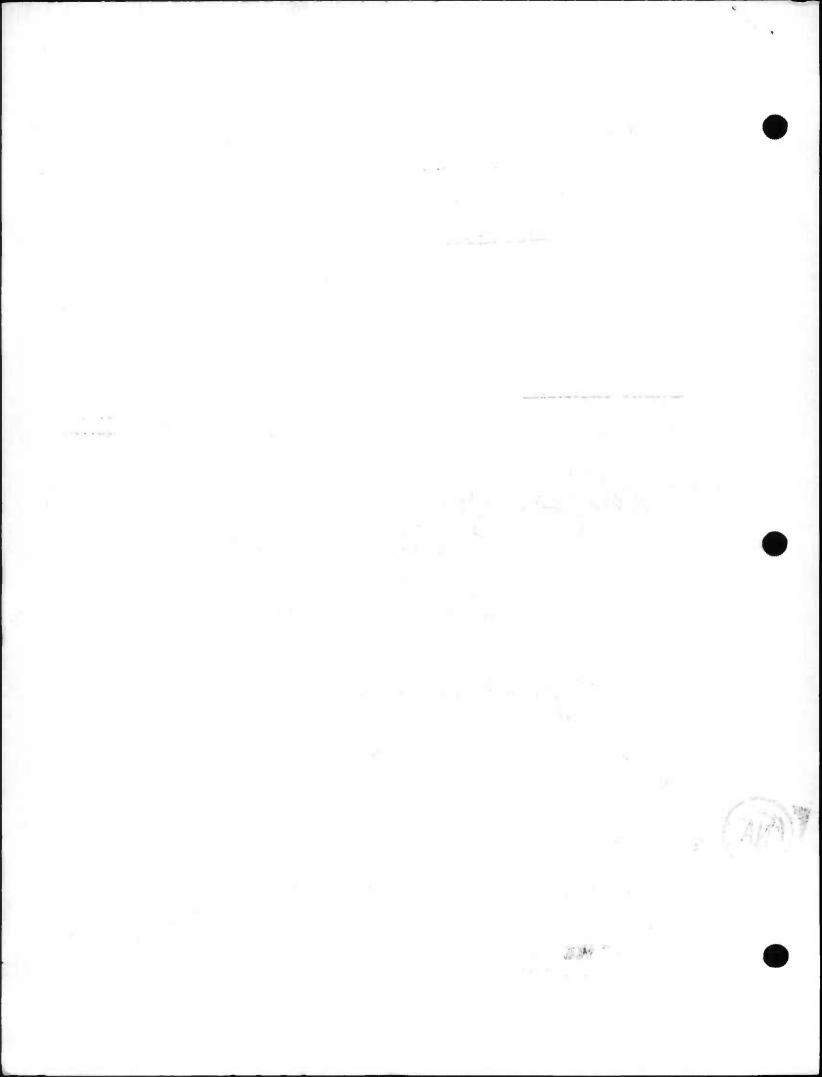
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	TU, THE HOSP BL. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-24 hours after death. Page 6 may be retained by the hospital or	THE MULEAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for u	emerged by the state of the sta	INPORTANT II light 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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	1 - FOR STATE OF REGISTRAR	MARYLAND /	DEPAR	TMENT OF H	EALTH AND I	MENTAL HYGI		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	1	3. TIME OF DEATH
	BESSIE	MODI.TI	N			Februar	y 12,	1995
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. les	st birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year		BIRTHPLACE (State or Foreign Country)
	217-38-1797 1 M 2 X 1 9a. FACILITY NAME (If not institution, give street and number)	73	YRS.		PR LOCATION OF DE	Mar. 6,	1921	Virginia
DIRECTOR	1810 W. Lafayette Avenue	2		Balti				N/A
EC	10a. STATE 10b. COUNTY		10c, CIT	r, TOWN OR LOCAT	ION			10d, INSIDE CITY
	MD N/A		Bal	timore				LIMITS? 1 X YES 2 NO
FUNERAL	1810 W. Lafayette Avenue	2		10f.	21218			S.A.
S	11. MARITAL STATUS 12. WAS DECED	ENT EVER IN U.S. AR	MED	13. WAS DECI	ENDENT OF HISPAN	NC ORIGIN? (Specify	Yas or No-	14. RACE — American Indian,
		1 YES 2 X	40	If yes, spe	ecify Cuban, Maxica 2 NO Specify	n, Puerto Rican, etc.)		Black, White, etc. Specify:
D BY	3 Vidowed 4 Divorced				••			Black
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(G	CEDENT'S live kind of w Do NOT us	USUAL OCCUPATIO	N st of working	186. KIND OF	BUSINESS/IND	USTRY
PLE	Elementary/Secondary (0-12) College (1-4 or N/A Master's	5+)	each					
OM	17. FATHER'S NAME (First, Middle, Last)	,	Cacin	CL	18 MOTHER'S NA	ME (First, Middle, Mail	den Cumama)	
Ü	William Carter				Bessie 1		oen someme)	
BE (19a. INFORMANT'S NAME (Type/Print)	191	b. MAILING	ADDRESS (Street ar		Route Number, City or	Town, State, Zip	Code)
2	William Modlin					imore, M		
	20a. METHOD OF DISPOSITION 1X Burtal 2 Cremation 3 Removal from State	20b. PLACE A		F DISPOSITION (Nat	me of	DATE 20c.	LOCATION —	City or Town, Stata
	4 Donation 8 Ofther (Specify)	Arbut	tus M	emorial			butus	, MD
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE				Funeral	Home Eas	st	
	1 AMILLOUNG	FIND		1101 i	E. North	Avenue/E	Baltimo	ore, MD 21202
	23. PART i. Enter the diseases, or complications shock, or heart failure. List only one	euse on each line						
	IMMEDIATE CAUSE (Final disease or condition	+ 1	1	1131	DT,	1 1 .		interval Between Onset and Death
	resulting in death)	ette M	000	ardia	- July	arction	2	10 hys
_1		OR AS A CONSEC	ADENCE OF):	U			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	O (OR AS A CONSEC	DUENCE OF):				
S	cause. Enter UNDERLYING CAUSE (Disease or injury							
E	that initiated events	O (OR AS A CONSEC	DUENCE OF):				
H	resulting in death) LAST							
AL C	PART II. Other significent conditions contributing	to deeth but not re	esuiting in	n the underlying	ceuse given in	Part i. 24a. WAS	AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
2						PERI	ORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEC						_ ' '	2 100	OF DEATH? 1 ☐ YES 2 ☐ NO
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO C	AUSE OF DEA	TH YE	S NO	UNCERTAIN	10		1
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLAC	E OF DEAT	H (Check only one)				
YSI	1 YES 2 NO 1 Inpetiant 2	☐ ER/Outpatient 3	□ DOA	OTHER: 4 - Nursing Home	5 Rasidence	8 Other (Specify)		
PH	27. MANNER OF DEATH 1 Natural 5 Pending	Dey, Year)	28b. TIME INJU		JRY AT PK?	28d. DESCRIBE HO	W INJURY OCC	CURED
В	2 Accident Investigation				ES 2 NO			
ED	3 Suicide 8 Could not be buildin	OF INJURY — At horg, atc. (Specify)	me, farm, si	reet, factory, offica		201. LOCATION (Stre City or Town, Str		or Rural Route Number,
BB-COMPLETED	29a. CERTIFIER							
P P	Check only CERTIFYING PHYSICIAN: To the beat							
8		axamination and/or i	nveatigation	i, in my opinion, de	ath occured at the	time, data and place,	and due to the	a cause(s) end manner as stated.
	206. SIGNATURE INDICATE OF CERTIFIER ME)			D25	391	29d. DATE ▶ 2	SIGNED (Month, Day, Year)
2	30 MAME AND ADDRESS OF PERSON WHO COMPLETED CA	Suse of DEATH-ITEM	4 27) Type,	Print) Balh	intol	- M2	21-	239
	31. DATE FILED (Month, Day, Year) FEB 1 5 1995	RAR'S SIGNATURE						
	FEB 1 5 1995 Jaly Sturie	ar Redall						



DISSION OF VITAL RECORDS, P.O. BOX 68	THE HOSPITAL CONTINUES PHYSICIAN: The law requires that the death certificate be execu-	TO THE FLIVERAL TOWN OF THE PARTY OF THE CERTIFICATE has been signed by the attending physician and	or filed with a 72 mun, after man, with the State Dept. of Health and Mental Hygiene prior to burn	MPORTANT TEAM OF Its marked, or item 23 shows any injury, or other traumatic

	1 - FOR STATE OF MA	RYLAND / DEPARTMENT OF HEA CERTIFICATE OF D	ALTH AND MENTAL HYGIEN DEATH REG. NO.	=			
	1. DECEDENT'S NAME (First, Middle, Last)	MOHRING	2. DATE OF DEATH MONTH DA				
	099-24-4143 1□ M 2 🚉		F UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 2 - 7 - 1 9 0 4	6. BIRTHPLACE (State or Foreign Country) GERMANY			
10R		NG HOME LAURI	LOCATION OF DEATH	9c. COUNTY OF DEATH			
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	10c. CITY, TOWN OR LOCATION	v	10d. INSIDE CITY			
	MARYLAND PRINCE GOT	GE LAU		1 WES 2 X NO			
FUNERAL	6611 CARLETON COURT		7 0 7	10g. CITIZEN OF WHAT COUNTRY? USA			
F. N.	11. MARITAL STATUS 1 Never Married 2 Married FORCES? 1	VER IN U.S. ARMED 13. WAS DECEN	DENT OF HISPANIC ORIGIN? (Specify Yes ty Cuban, Maxican, Puerto Rican, stc.)				
ED BY	3 X Widowed 4 Divorced IF YES, GIVE WAR	OR DATES 1 YES 2		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
ETE	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.)	d working 16b. KIND OF BUS	SINESS/INDUSTRY			
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5 +)	HOMEMAKER	номе				
	17. FATHER'S NAME (First, Middle, Last) HEINRICK PANATELMANN Heinric	k Pantelmann	8. MOTHER'S NAME (First, Middle, Maiden				
BE	196. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and	JOHANN (UNKNOWN Number or Rural Route Number, City or Town				
2	JOAN SAUPER	1	COURT, LAUREL, M				
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Ramoval from State	20b. PLACE AND DATE OF DISPOSITION /Name	of DATE 20c LOV	CATION City of Town State			
	4 □ Donation 6 □ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	BALTIMORE WASHINGT	ADDRESS OF FACILITY FIECK I	UNERAL HOME, INC.			
	1 (alala da)	60 7601 S	ANDY SPRING ROAD,	LAUREL, MD 20707			
	23. PARY I. Enter the diseases, or complications that a shock, or heart failure. List only one gauss	use the death. Do not enter the mode	of dying, auch as cardiac or respi				
	IMMEDIATE CAUSE (Final disease or condition		cide	Interval Batween Onset and Death			
	resulting in death) a. DUE TO (OR	AS A CONSEQUENCE OF):					
NO	Sequentially list conditions,	promo					
CATI	If any, leading to immediate cause. Enter UNDERLYING	AS A CONSEQUENCE OF:	deser				
CERTIFICATION	CAUSE (Disease or Injury	AS A CONSEQUENCE OF):					
CER	d						
CAL	PART II. Other algnificant conditions contributing to de	- 10	suse given in Part I. 24a. WAS AN PERFORE	MED? AMILABLE PRIOR TO			
MEDI	- Ingenial	Demaljia	1 TES 2	or seamin			
N. N		V		1 NES 2 NO			
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ANO 1 Input lant 2 EF	QTHER:	E OF DEATH (Check only one)				
PHYSICIAN:	27. MANNER OF DEATH 28s. DATE OF INJ	URY 28b, TIME OF 28c, INJURY	5 Residence 6 Other (Specify) (AT 28d, DESCRIBE HOW IN	NJURY OCCURED			
ВУ	2 Accident Investigation	M 1 TYES	2 NO				
ETED	3 Suicide 8 Could not be determined determined determined determined determined						
COMPLET		knowledge, death occurred at the time, date end nation and/or investigation, in my opinion, death					
TO BE (29b. SIGNATURE AND TITLE OF CENTIFIER	Terral Phys	D 19897	29d. DATE SIGNED (Month, Day, Ybar)			
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	1 A HANOVER	PARKWAY	GREENGELT			
	31. DATE FILED (Month, Day, New) FER 15' 150 FLA Officer A REGISTRAR'S	signature bor Ranka W		mD 26170			



DHMH-16 Rev 1/89

d by the hospital or attending physician. Id be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020 SION OF VITAL RECORDS, P.O. BOX 68760

retained	5 shoule	
nay be	page ;	
NG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained	fter this certificate has been signed by the attending physiclan and completely filled in by the funeral director, page 5 shouk	
death.	funeral	
after	y the	non
SIT	in D	ram.
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death c	attend	Antai My
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SICIA	certi	the
PHY	this	with
9	fter	aath

_		FOR 1 - STATE REGISTRAR	STATE OF I	MARYL					HEALTH DEA		MENT	AL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last)	C,		Mo	,61	ey	, Jr			MOR	TE OF DEATH	ÂÝ	95	3. TIME OF DEATH
		217-44-0311	5. SEX 1 ∑ M 2 ☐ F	8. AGE (in yrs. lest birthdey) Junder 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.					(Mo	re of Birth onth, Day, Year) -6-1914		Count	NPLACE (State or Foreign ry) SISSIPPI		
00		9a. FACILITY NAME (If not institution, give street and number) Laurel Regional Hospital RESIDENCE OF DECEDENT				9b. CIT		on Locati	-3/000	ATN			ince	George	
DIRECTOR		10a. STATE 10b. COUNTY			Т	10c. CITY	, TOWN	OR LOCA	TION						10d. INSIDE CITY
	- 44		rince G	eorge	e .				aure						LIMITS? 1X YES 2 NO
FUNERAL		510 6TH Street						10	4. ZIP COD 20	707			10g. CIT	USA	WHAT COUNTRY?
à		11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 NO			If yes, sp	CENDENT Concity Cubs	an, Maxican	n, Puert	GIN? (Specify Ya to Rican, etc.)	or No —	Blac	E — American Indian, k, Whita, etc.
		15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)		(Ghu	EDENT'S	rork done	during me	ON ost of workli	na	-10	6b. KIND OF BU	SINESS/IN	DUSTRY	
PLET		Elementary/Secondary (0-12)	College (1-4 or 5	+)		oo NOT us ECTR			IGINE	ER		FO	cc/iis	COV	ERNMENT
TO BE COMPL		17. FATHER'S NAME (First, Middle, Last)				10 I K	20111	<u> </u>	18. MOT	HER'S NAM		t, Middle, Maiden	Sumame)		
BE BE		Milton C. Mobley,	Sr.		401	***		0.70				Bennet		-	er
100		Sara Mobley										mber, City or Tow Maryla			
ust be		20a. METHOD OF DISPOSITION 1 X Burtal 2 Cremation 3 Ramo	val from State	cem	PLACE AN	etory or of	her plecel				1		CATION -		1
mer m		4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE, O	- It	vy Hi	111 (Ceme	tery	ND ADDRE	SS OF FAC	2/	14 Lau	rel,	Mar	yland Home, Inc.
examiner must		1 (alass	Dulbe	abe	Si			7601	San	dy S	pri	ng Road	l, La	urel	, MD 20707
event, the medical		23. PART/I. Enter the diseases, or communications that caused the death. Do not anter the mode of dying, such as cardiac or reapiratory arrest, ahock, or heart failure. List only one cause on each line. 1/29, 2/3, Approximate interval Between Onset and Death disease or condition resulting in death) DUE TO (Off AS A CONSEDUENCE OF):													
or other traumatic	-	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OF AS A CONSEDUENCE OF): Ventr' cular arrhythmia E hour DUE TO (OR AS A CONSEDUENCE DF): Renal failure - acute and chronic 7 days DUE TO (OR AS A CONSEDUENCE DF): C. Gastroin testinal bleeding 8 days													
any inju		PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. Hemoptys's Preumania 1 yes 2 pro of DEATH?													
3 shows N: MEC		DID TOBACCO USE CONTR	IBUTE TO CA	USE O	F DEAT	H YE	S 🗆	NO S	T UNC	ERTAIN					1 YES 2 NO
SICIAN	Ì	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSBITAL:		26. PLACE	OF DEAT	H (Check								
ं ≥		1 VES 2 NO 27. MANNER OF DEATH	1 € inpatient 2 ☐ 28e. DATE DF (Month, D	INJURY		DOA 28b. TIME	4 🗆 Nur	aing Hon 28c. INJ	URY AT	asidence (her (Specify) ESCRIBE NOW I	NJURY OC	CURED	
mary B	1	1 Natural 5 Pending 2 Accident Investigation			41.50=		м	1 🗆	YES 2	-					
TED	1	3 Suicide 8 Could not be determined	28e. PLACE D building,	etc. (Speci	Hy)	e, tarm, s	reet, tact	югу, отно	•		261. LO	CATION (Street ty or Town, State)	and Number	r or Rural f	Roule Number,
COMPLET		29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSIC 2 MEDICAL EXAMINER													and manner as stated
	t	296. SIGNATURE AND THREE OF CERTIFIED	2 0	200	-	2-				ENSE NUMI					(Mgrith, Day, Year)
TO BE		30. NAME AND ADDRESS OF PERSON 19/10	COMPLETED CAUS	SE OF DEA	STH (ITEM :	27) (lype	Prints	9	D	39	5	32	> 2	2/10	195
		Timothy McC 31. DATE FILED (Month: Day, Year)	Cah 32 DEGISTRA	32 R'S SIGNA	1 0			Gei	nge	-57:	:	aure	/ /	10	20707

F .

FOR STATE

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG.	NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEAT	Н		3. TIME OF DEAT	'n
	MARY FRA	NCES	MIKI	JLA		Februar	DAY	1995	3:19	D M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. A	NGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT			HPLACE (State or Fo	
	159-24-5825	1 FO C / FOOF Month, Day, Year)								
	9a. FACILITY NAME (If not institution, give street		7,7					<u> </u>	nsylvani	La
					OR LOCATION OF DI	EATN		UNTY OF C		
0	Berlin Nursing & R	enabilita	tion Chtr.	Ber	lin		Wo	orces	ter	
DIRECTOR	10a. STATE 10b. COUNTY		ile. CIT	Y, TOWN OR LOCAT	TION				10d. INSIDE CITY	
E	Maryland Wo	rcester			lin				LIMITS? V	
	10e. STREET AND NUMBER								1 TES 2	NO
A A	2980 Ocean Pines			101	21811		10g. CI		WHAT COUNTRY?	
y H									J SA	
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married	FORCES? 1 1	ER IN U.S. ARMED		ENDENT OF NISPAI ecity Cuban, Mexica			14. RAC Blac	E — American India k, White, etc.	in,
B	3 🔀 Widowed 4 🗆 Divorced	IF YES, GIVE WAR	OR OATESX		2 NO Specif		-7		White	
	*							<u> </u>		
H	15. OECEDENT'S EDUCA (Specify only highest grade co		(Give kind of	Work done during me	ON ist of working	16b. KIND O	BUSINESS/IN	OUSTRY		
Ш		College (1-4 or 5+)	life. Do NOT u	.112.0			_			
3 ₹	12 0		Comput	er Analy	st	US	overn	nent		
COMPLETED	17. FATNER'S NAME (First, Middle, Last)					ME (First, Middle, M.	iden Sumame)			
BE CON	William Davitt				Mary I	avis				
10	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	AOORESS (Street a	and Number or Rural	Route Number, City of	Town, State, 2	ip Code)		
- 1	Kathleen M. Koppel:	man	2980	Ocean Pi	nes, Ber	clin, Mar	yland	2181	.1	
	20a. METNOD OF DISPOSITION		20b. PLACE AND DATE	OF DISPOSITION /No	med	OATE 20	LOCATION -	- City or To	own, Stata	
	1 Burial 2 Cremation 3 Remove 4 Donation 5 Other (Section)	al from Stata	Arlington	"Nationa	1 Cem.	1/9	rling	on.	Virginia	3
	21. SIGNATURE OF FUNERAL BERVICE LICES	(Esta	0		NO ADDRESS OF FA					
-	1/1000	oto.Ch	ach/							
	- Maai	WWW.	Way		Sandy S	_			., MD 20	/0/
	23. PART I. Enter the diseases, or con shock, or heart failure. Lie	mplications that ca	med the neath. Do	not antar the mo	da of dying, suc	h as cardiac or i	eaplratory a	rrest,	Approxim	
	IMMEDIATE CAUSE (Final	at only one cause o	in amonthing	\					Onset and	
	disease or condition	PATO	210000	Detre	2/00	+ D.	0011		R 1	2
	resulting in death)	OUE TO (OR	AS A CONSEQUENCE O	Pi:	xycar	Jac la	eur		177	29,
_		(0040A	aliel	a Shor	Hear	eserie			100	4
Õ	Sequentially list conditions, b.	OUE TO (OR	AS A CONSEQUENCE O	FI:		Loves			109	2
Ā	If any, leading to immediate cause. Enter UNDERLYING			•					ĺ	
CERTIFICATION	CAUSE (Disease or Injury that initiated events	DUE TO (OR	AS A CONSEQUENCE O	F):						
E	resulting in death) LAST									
S	d								+	
DICAL	PART II. Other algnificant conditions	contributing to das				Part I. 24n. WR	S AN AUTOPSY	248	. WERE AUTOPSY FI	
5	1, C-VA 2	. atrial	Fibre	Clatin	(2)	100	RFORMED?		AVAILABLE PRIOR COMPLETION OF C	
MEC	3. Preumonite	is with	Methicelle	: Kesi	Les A	_ '''	S Z M NO		OF DEATH?	
	Stepl Dure	11 4 NA	11		TO	7		- 1	I TYES 2 X	40
A	25. WAS CASE REFERRED TO MEDICAL	Co. F. KI	semip	-	Jennen.	aa				
PHYSICIAN:	EXAMINER?	HOSPITAL:		OTHER:	ACE OF OEATN (Ch					
≥		Inpatient 2 ER			e 5 Residence					
표	27. MANNER OF DEATN 1 X Natural 5 Pending	(Month, Day, Ye	JRY 28b. TIN		URY AT	28d. OEŞCRIBE H	O YRULMI WO	CCURED		
B	2 Accident Investigation			M 1 🗆	YES 2 NO					
	3 Suicide 6 Could not be	28s. PLACE OF IN. building, atc.	IURY — At home, larm, (Specify)	atreet, factory, offic	•	281. LOCATION (S City or Town,		er or Rural	Route Number,	12
	4 Nomicide determined					ony or rowin,				
COMPLETE	29a. CERTIFIER I X CERTIFYING PHYSICIA	AN: To the bast of my l	cnowledge, death occurr	ed at the time data	and place, and du-	to the carredat and	manner en et	eted		
ĭ.	(Check only one) 2 MEDICAL EXAMINER:								a) and meaner at	Istad
8				,, opinion, u			=, =:NJ UVE 10	cedse(-, end manner as \$	weed.
H	296, SIGNATURE AND TITLE OF CENTIFIER	20 (2		29c. LICENSE NUI		29d. DA	TE SIGNED	(Month, Day, Year)	
ဥ	Musee	Coxx	RED		D29505)				
-	Creation Della Territoria				c	.m. 0101		0.66		
14	Gregorio Belloso	- Manual Control	Ada Us	PI. Cri	stield	MD 21817	410-	-968-	1801	
	"FEBLE (15 11395) XW	SZ. REGISTRAR'S	SIGNATURE							
	1 - 1 - 10 - 10 - 10									

ding physician,	the burial-transit permit. Pages 1-2 3 should		
death. Page 6 may be retained by the hospital or atter	e funeral director, page 5 should be detached for use a	78	examiner must be notified at once.
VSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1, 2 should	h the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	narked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ATTENDING PHYSICIAN: The law requires that	CTUR: After this certificate has been signed b	after death with the State Dept. of Health an	28 is marked, or item 23 shows any
THE MANIETAL DR.	THE FUNERAL/DIRE	the field within at hours	IMPORTANT: If Item

											9.		14541
	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND	/ DEPAR	TMEN	T OF H	EALTH	AND N	MENTA	L HYGIEN	E		
	1. OECEDENT'S NAME (First, Middle, Last)						DEA		2. DATE	OF DEATH			3. TIME OF DEATH
	JOSEPH PETER MITCHE	ELL						- 4	MONT		.,	YEAR	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	lest birthday)	IF UNDER	R 1 YEAR	IF UNDER	24 HRS.		OF BIRTH	199.		4:40 A. M
	014-14-8477	1XX M 2 - F	8	2 YRS.	MONTHS	DAYS	HOURS	MIN.	(Monti	n, Day, Year) L. 16, 19	112	Count	SACHUSETTS
	9a. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY	(TOWN O	R LOCATI	ON OF DE		L 10, 13		INTY OF C	
E .	MONTGOMERY COUNTY GENE	PAL HOSDI	ΓΔΙ			OLN						ONTGON	
18	RESIDENCE OF DECEDENT	INAL HOOF I	I A L			OLIVI					Pit	JIVI GOI	ILIVI
DIRECTOR	10e, STATE 10b, COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION		-				10d. INSIDE CITY LIMITS?
1		GOMERY				SIL	VER SI	PRING					1)(X) YES 2 NO
FUNERAL	100. STREET AND NUMBER 905 HERON ORIVE					10f.	2090				10g. CIT	USA	WHAT COUNTRY?
F												UJA	
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. A		13.	WAS DECI	ENDENT C	F HISPAN	IC ORIGIN	? (Specify Yea Rican, etc.)	or No-	14, RACI	E — American Indian, k, White, etc.
B	3 (Widowed 4 Divorced	IF YES, GIVE V						Specify.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Spec	
	15. DECEOENT'S EDUC		16a. C	DECEDENT'S	USUAL O	CCLIPATIO	M		166	. KIND OF BUS	INEGO/IN	DUETRY	
E	(Specify only highest grade Elementary/Secondary (8-12)	completed) College (1-4 or 5		(Give kind of the Do NOT us	work done se retired.)	during mos	st of working	g	100	KIND OF BUS	INESS/IN	DUSTRI	
COMPLETED	12	6		IVILEN	GINEE	R				U S GOVE	RNME	TV	
ō	17. FATHER'S NAME (First, Middle, Lest)						18, MOTH	ER'S NAM		Aiddle, Maiden S			
ш	CHARLES KASMIR MISKAVI	CH						TRICE		THE WASHINGTON			
0	19a. INFORMANT'S NAME (Type/Print)		1	9b. MAILING	ADDRESS	S (Street er	nd Number	or Rural R	oute Numb	oer, City or Town	. State. Zi	p Code)	
유	ALYCE O. SHENK									ARYLANO			
	20a. METHOD OF DISPOSITION		20b.PLAC	E AND DATE	OF DISPOS	SITION /Na/	me of		DATE	_	-	City or To	own. State
	1 Description 5 Cremation 3 Remo	wal from State	_ cemetery, c	NO VET	ERANS	CEME	TERY		2/1	6 CHELT			
1	21. SIGNATURE OF JUNERAL SERVICE LIC	ENSEE	11		22.	NAME AN	D ADDRES	S OF FAC		FLECK FL			
	1000000	X allow	1000		4	7601	SANO	Y SPR	ING R	OAO, LAU	JREL,	MARYI	ÁND 20707
	23. PART i. Enter the diseases, or c	ompligations the	t caused the	leath. Do r	ot enter	tha mod	de of dyi	na, such	aa cerd	lac or respir	atory ar	reat.	Approximata
	ahock, or heart failure. I IMMEDIATE CAUSE (Finei	List utily one cat	me on each lir	10.							257		interval Between Onset and Death
	disease or condition	INO	mmia	1									13 days
	resulting in death)		(OR AS A CONS	EOUENCE O	·):				-				320291
z													
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONS	EOUENCE O	7:						· · · · · · · · · · · · · · · · · · ·		
3	cause. Enter UNDERLYING CAUSE (Disease or injury												
TE	that initiated events resulting in death) LAST	DUE TO	(OR AS A CONS	EOUENCE O):								
	resolding in death) LAST												
D T	PART II. Other significent conditions	contributing to	death but not	resulting	n tha un	derlying	cause o	Iven in F	Part I.	24a, WAS AN	UITOPSY	24h	. WERE AUTOPSY FINDINGS
MEDICAL	Pacemoker Porc Cerchinunscular	INC MITT	of VALUE	,						PERFORI	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
ED	Comboly as a. l.	Accede	.+						- 1	1 TYES 2	NO		OF DEATH?
	DID TOBACCO USE CONTR	IBLITE TO CA	LISE OF DE	ATH VE	s \square i	ио П	LINIC	ERTAIN					1 YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL	IDOIL TO CA		CE OF DEAT			ONC	CKIAIN	<u>, </u>				
PHYSICIAN:	EXAMINER?	HOSPITAL:			OTHER	3:							
НΥ	27. MANNER OF DEATH	28e. DATE OF	INJURY	28b. TIM	E OF	28c. INJU	JRY AT	sidence 8		CRIBE HOW IN	JURY OC	CURED	
	1 Natural 5 Pending	(Month, D.	ay, Year)	INJ	URY M	1 Y	es 2					001120	
э ву	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE O	F INJURY — At H	oma, farm, s	treet, fact			-	28f. LOC/	ATION (Street or	nd Number	r or Runal F	Route Number.
TED	4 Homicide determined	building,	etc. (Specify)						City o	or Town, Stete)			
	290. CERTIFIER (Check only 1 CERTIFYING PHYSIC	IAN: To the heat of	my knowledge of	leath occur	d at the t	ma deta	and elec-	and a	a th-	an(a) d	A. 141	641	
COMPÉET	(Check only one) 2 MEDICAL EXAMINER) and manner as stated
	296. SIGNATURE AND TITLE OF CERTIFIER					1				piece, eliq			
BE	Getter Selver	lina	A-H	6.7		,,		NSE NUM			29d. DAT	E SIGNED	(Month, Day, Year)
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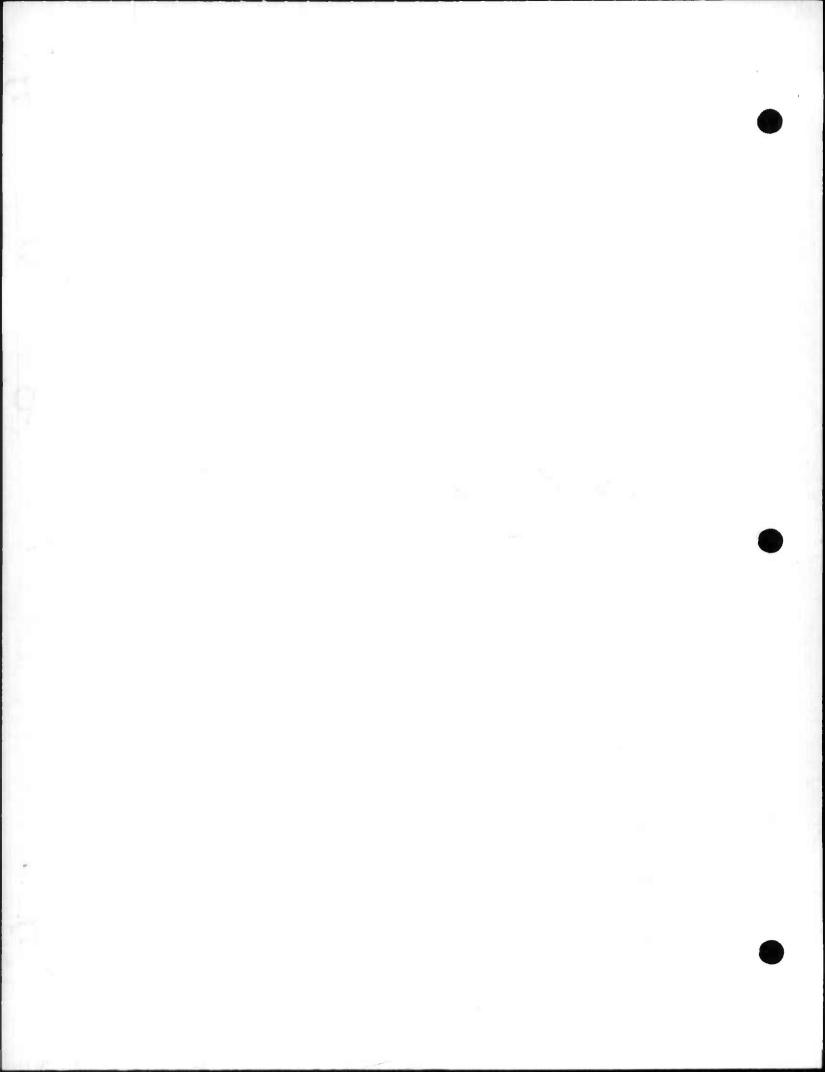
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Phily Dr., Ulat 32 REGISTAR'S SIGNATURE Sura Discussion Condall

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31. DATE FILED (Month, Day, Year)
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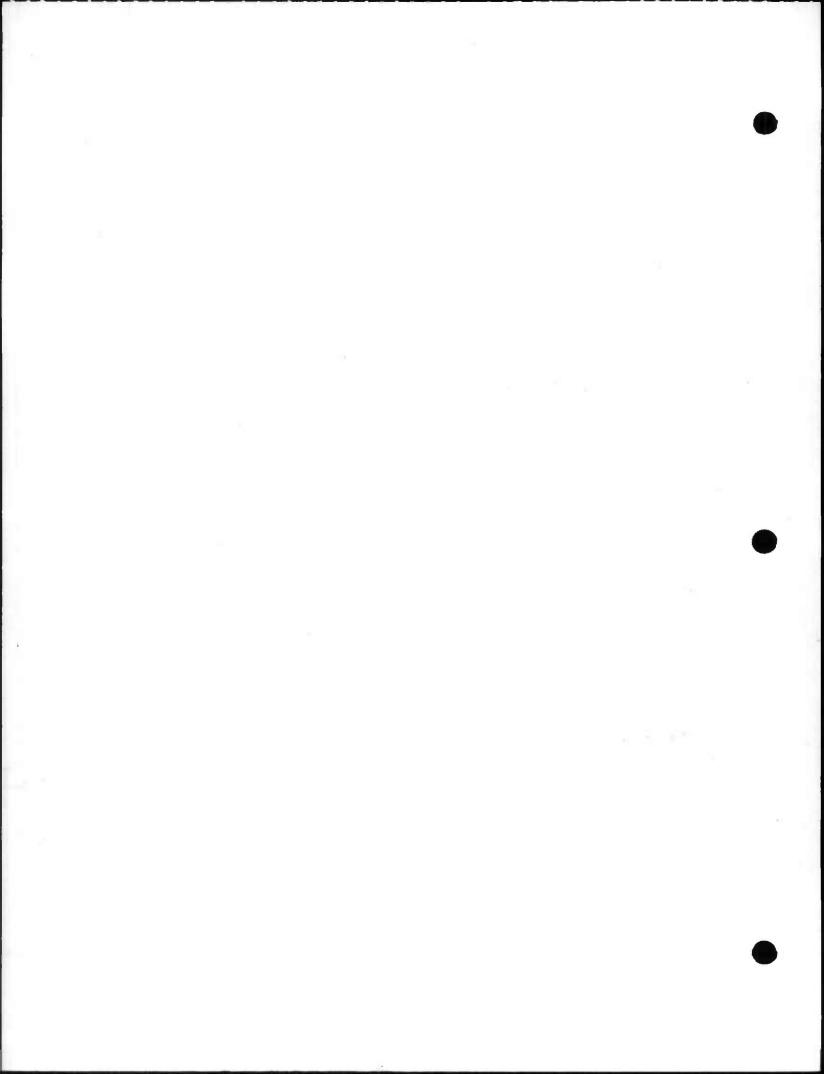
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DIVISION OF VITAL RECORDS, P

after death. Page 6 may be retained by the hospital or attending physician.	by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages	ical examiner must be notified at once.	
TO THE HOSPITH OF MENOWS PHYSICIAN: The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hospital or attending physician.	TO THE EXPLICATION AND THIS CERTIFICATE has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1,	IMPORTANT II tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	O DE COMBIETED DV BUVOICIANI, MEDIONI OTENIONI

	FOR 1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPARTM CERTIFICA			MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)	G. /	MULLINS			2. DATE OF DEATH	AV Z	1 TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 216-36-8607	1 XX / 2 □ F	(In yrs. last birthday) IF (MON	THE DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 12-14-19	170	Country) W. Virginia
TOR	90. FACILITY NAME (If not institution, give str Joseph Richey)		9b.		r LOCATION OF DE	АТН	9c. COUNTY	
DIRECTOR	10a. STATE 10b. COUNTY Maryland		10c. CITY, TO	WN OR LOCAT	imore			10d. INSIDE CITY X LIMITS? 1 YES 2 NO
	10e. STREET AND NUMBER 3510 Beech Ave:	nue Apt. F	3	101.	ZIP CODE	211		OF WHAT COUNTRY?
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ABMED	If yes, spe		HC ORIGIN? (Specify Yea n, Puerto Rican, etc.)		RACE — American Indian, Black, White, atc. Specify: White
LETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S USU. (Give kind of work of We. Do NOT use reti Custod	done during mos red.)	N It of working	16b. KIND OF BUS		
COMPL	17. FATHER'S NAME (First, Middle, Last) William L.	Mullins	Custou	Tan		ME (First, Middle, Maiden	Sumame)	creaming
TO BE	19a. NFORMANT'S NAME (Type/Print) Jack Dailey					Poute Number, City or Tow Orive Bal		
	20a. METHOD OF DISPOSITION 1 Street Burlet 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	wal from State 20	b. PLACE AND DATE OF DIS	sposition (National National N	tery 2		cation – city odlawn	or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LICE	ensee arpi	nter		o ADDRESS OF FAC ee-Hens Falls	Funera Rd Balt		ne) 21211
HIFICALION	23. PART I. Enter the seases, or or shock, or heart fellure. L. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) Sequentielly liet conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events.	OUE TO (OR)ES	A CONSEQUENCE OF: A CONSEQUENCE OF: A CONSEQUENCE OF: A CONSEQUENCE OF:	riter the mod	Ap	h as cardiac or respi	ratory arrest,	Approximete Interval Between Onset and Death VY7144 CS
CER	PART II. Other algoriticent conditions	Cavein	o MA		ectu,	an.		4 mos
MEDICAL	. Other argumeent conditions	Contributing to deeth t	out not resulting in th	e underlying	ceuee given in	Part I. 24a. WAS AN PERFOR 1 TYES 2	MED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIDR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
H TSICIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF OEATH (C	heck only one)	UNCERTAIN	10		
ביים	1 U YES 2 WO 27. MANNER OF DEATH	1 Inpatiant 2 ER/Out	petient 3 DOA 4 DOA 28b, TIME OF INJURY	HER: Nursing Home 28c. INJU WOR	IRY AT	6 Other (Specify) 28d. DESCRIBE HOW II	_//	ICE.
19 01	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be determined		Y At home, ferm, street	M 1 🗆 Y	ES 2 NO	281. LOCATION (Street a City or Town, State)	and Number or R	Tural Route Number,
APCE.	29a. CERTIFIER (Check only	CIAN: To the best of my know						
DE CO	206 SIGNATUM AND THE OF CONTINER	On the basis of exemination	en end/or Investigation, in	my opinion, de	29c, LICENSE NUM			SNED (Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type, Print	28/1	· Euta	ensy-V	Sorth	Marso
	31. DATE EN ED (Month, Day, Voet) FEB 1 5 1995	32. ASSIST AR'S SA	AL CALL	0				



burial-transit permit. Pages 1, 2, 3 should

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within after death. Page 6 may be retained by the hospital or attending
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF H		MENTAL HYGIENE REG. NO.	Ē	
	1. DECEDENT'S NAME (First, Middle, Last)	M	IMMS			2. DATE OF DEATH MONTH, DAY	Y YEAR	3. TIME OF DEATH
	HATT	IE "	TMMS			Teb is	4	8:55 PM
	4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT Coun	HPLACE (State or Foreign
	239-18-6484 A		81 YAS.			April 15,1	.913 No	rth Carolina
~	Sa. FACILITY NAME (If not institution, give str		1	2	R LOCATION OF D	DEATH	9c. COUNTY OF	DEATH
õ	Liberty Medical	Center		Balti	.more			
E C	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCATI	ON			10d. INSIDE CITY
2	Maryland		Ba	altimore	۵			LIMITS?
AL	10e. STREET AND NUMBER				ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL DIRECTOR	4218 Elderon Aven	ue		2	21215		USA	
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DECE	NDENT OF HISPA	NIC ORIGIN? (Specify Yee	or No- 14, RAC	E American Indian, ik, White, etc.
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA			2 NO Speci	en, Puarto Rican, atc.) lly:	Spec	olfy:
	15. DECEDENT'S EDUC	ATION	44- DECEMBER 18	1		Towns at a street		Black
COMPLETED	(Specify only highest grade of	completed)	(Give kind of wor life. Do NOT use	SUAL OCCUPATION rk done during mos retired.)	n t of working	16b. KIND OF BUS	NESS/INDUSTRY	
7	Elementary/Secondary (0-12) 5th Grade	College (1-4 or 5+)		worker		Uoltita	Rubber	Company
8	17. FATNER'S NAME (First, Middle, Last)		ractory	WOLKEL		AME (First, Middle, Maiden S		Compily
	Barnett Withers					Womack	corrective)	•
) BE	19e. INFORMANT'S NAME (Type/Print)	· · · · · · · · · · · · · · · · · · ·	19b, MAILING A	DDRESS (Street an		Route Number, City or Town,	State, Zip Code)	
5	Anna Mimms Copela	nd COPLIN		deron A		Baltimore,		nd 21215
	20a, METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Remove	20b.	PLACEAND DATE OF	DISPOSITION (Nam		DATE 200 LOC	ATION CHARLE	nun Chata
	4 Donation 8 Other (Specify)	Ar	tery, crematory or other butus Men	norial F	ark	Feb 17 Balt	imore C	ounty, MD
	21. SIGNATURE OF FUNERAL SERVICE LIDE)		22. NAME AND	ADDRESS OF FA	alls Parkwa	uneral	Homes, Inc
	+Seven +	ackee		Baltin	ore. Ma	ryland 212	1y 216	
	23. PART I. Enter the diseases, or co	omplications that caused list only one ceuse on ee	the deeth. Do not	t enter the mod	le of dying, auc	ch es cardiec or reapin	atory arrest,	Approximate
	iMMEDIATE CAUSE (Finel disease or condition reaulting in death)	DUE TO (OR AS A ODE TO (OR AS		a/ /n=	ferraction	1 suspec	real	interval Between Onset and Death
_]	_	A CA	ourseduence or):	his he	ment	diagram		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):	10		Cidence		
CAT	cause. Enter UNDERLYING CAUSE (Disease or injury	Conver	the has	sint +	silu-e			
E	thet initiated events	DUE TO OR AS A	CONSEQUENCE OF):	V				
ER	reaulting in death) LAST	Cordia	c arn	4thon	7			
AL C	PART ii. Other aignificent conditions	contributing to death bu	t not reaulting in	the underlying	cause given in	Part i. 24a. WAS AN A	UTOPSY 24	. WERE AUTOPSY FINDINGS
S				-0.00	-50-3-100	PERFORM	AED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
PHYSICIAN: MEDIC						1 🗆 YES 2 (INO	OF DEATH?
=						_		TE TES 2 IPRO
X I	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PL/	CE OF DEATH (C	heck only one)		
SIC		HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpar		THER:	5 🗆 Residence	6 Other (Specify)		
H	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME (OF 28c, INJU	RY AT	28d. OESCRIBE NOW IN	JURY OCCURED	
ВУ	1 Natural 5 Pending 2 Accident Investigation				ES 2 NO			
	3 Suicide 8 Could not be	28e. PLACE OF INJURY - building, etc. (Specif	- At home, term, stre	eet, factory, office		281. LOCATION (Street en City or Town, State)	d Number or Rural	Route Number,
	4 Nomicide determined							
P		IAN: To the best of my knowle						
COMPLETED	one) 2 MEDICAL EXAMINER	On the beale of examination	end/or investigation,	In my opinion, de	ath occured at the	time, date end place, end	due to the cause(e) and menner se stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIED				29c, LICENSE NUI	MBER	29d. DATE SIGNED	
10 B	-101-				D 3	494	D 02/	13/95
-	30. NAME AND AGORESS OF PERSON WHO	COMPLETEO CAUSE OF DEAT			141			
	THE PARK PRINCE OF THE PARK PRIN	DESAL MO	466	so WI	IKen A	re Ba	HIMME	M1) x 15x01
	31. DATE FILED (Month, Day, Your) FEB 1 5 1995	22. REGISTRAR'S SIGNAT	URE					
	1 0 1030	June Williams	want					

Items# 10.d.10 e G-film 2/15/05 FH D C

TO THE WEBAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled when 2 ben's after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. MOSPIECUA ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOS TO THE be filed will

1 6 6 11 10 17	10.0.10.0 0 111 ll per 1.11 2/15/95 1.0
	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIEN
RAR	CERTIFICATE OF DEATH

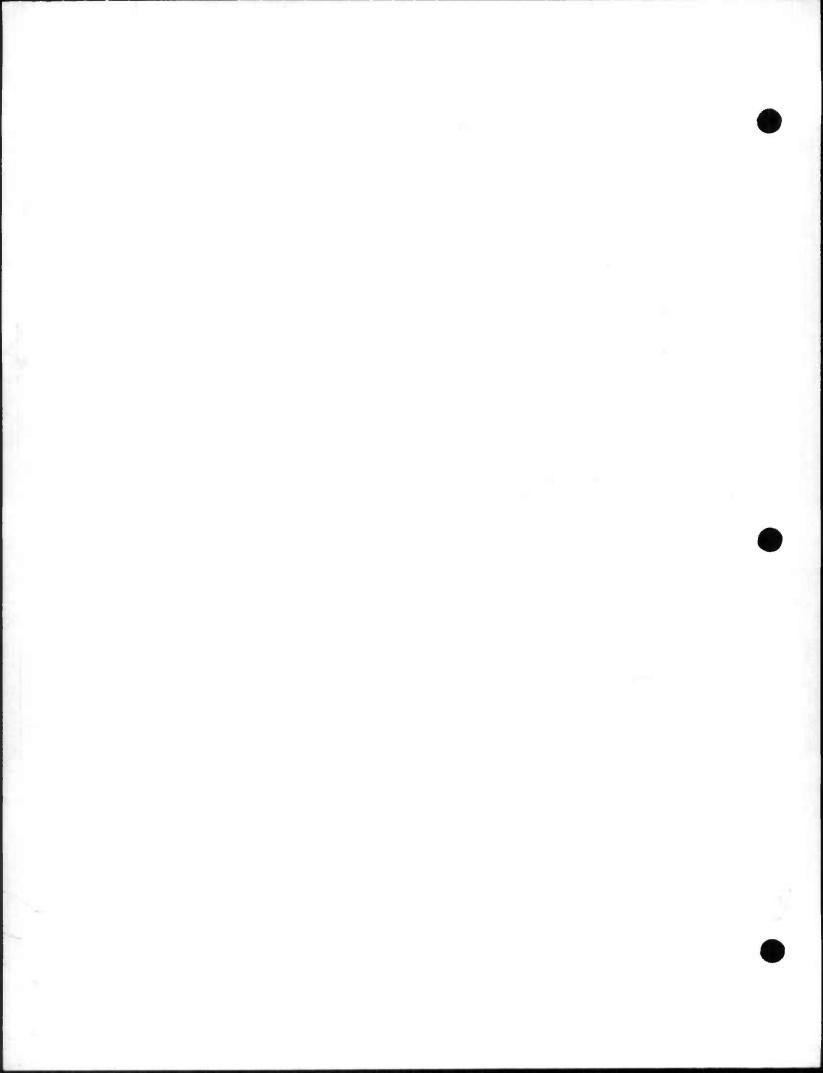
TORGETT MANAGE FOR ANALOGO AND		1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPARTI	MENT OF H			L HYGIEN			
THE BALLY MANUEL PREVIOUS PROTECTION OF CONTROL PROTECTION OF CONT			V				2. DATE MONTH	OF DEATH		YEAR	3. TIME OF DEATH
TO DESCRIPTION TO DESCRIPT STANDARD AND ADDRESS (Proceedings of Compileration Standard) 10		4 SOCIAL SECIPITY NUMBER									
The ANGLY MANE (For intelligence, the same and number) 1. A COUNT OF DEATH 1. A COUNT OF DE			404405				(Month	, Day, Year)	- 1	Country,	LACE (State or Foreign
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The street and designation of the street of	œ			[]			EATH		9c. COUNT	TY OF DE	ATH
The street and designation of the street of	5	RESIDENCE OF DECEDENT			Balt	ımore					
The street and designation of the street of	JE C		1	10c. CITY, 1	TOWH OR LOCAT	ION				T	10d, INSIDE CITY
STREET AND NUMBERS ACCOUNT OF THE PROPERTY STREET AND STREET AN	<u>a</u>	Maryland Ann	e Arundel	Ba	altimore	e					
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The state of the density of the state of the	EB	4609 Clareway	imberriel	d Place		21226	5			USA	
The state of the density of the state of the	5	11, MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DECI	ENDENT OF HISPA	NIC ORIGIN	? (Specify Yes		4. RACE	- American Indian,
Sequentially list conditions. No. DECEDENT S DUCLOTION (Chord on the first parts contributing to death but not resulting in the underlying cause given in Part i. 23. PART 1 Enter the diseases or complications the passed on the death of the section of the conditions of the cond			IF YES, GIVE WAR OR	DATES	If yea, spe	city Cuban, Mexic	an, Puerto F lly:	tican, etc.)			
The information and properties of the part						25					White
The information and properties of the part		15. DECEDENT'S EDUC (Specify only highest grade	Completed)	(Give kind of won	k done during mos	N at of working	16b.	KIND OF BU	SINESS/INDU	STRY	
The information and properties of the part	۳		College (1-4 or 5+)	1	_ ′						
The information and properties of the part	Ž			Flagge	er					atio	n
19. BMCDMBATTS MARE (Type-Print) 19. MARLING ADDRESS (Shored and Number or Rural Robus Number, Cay or Dam, State, Zip Codo) 46.09 Clareway, Baltimore, MD 21213 20. METHOD OF DISPOSITION 19. Burket 2 () Devention 3 () Other (Sporthy) 21. SIGNATURE OF VIEW DATE (Sporthy) 22. MARK ADD ADDRESS (Shored and Number or Rural Robus Number, Cay or Dam, State, Zip Codo) MOYEL AND ADDRESS (Shored and Number or Rural Robus Number, Cay or Dam, State, Zip Codo) 46.09 Clareway, Baltimore, MD 21213 20. MARK ADD ADDRESS (Shored and Number or Rural Robus Number, Cay or Dam, State, Zip Codo) MOYEL AND ADDRESS (Shored and Number or Rural Robus Number, Cay or Dam, State, Zip Codo) 46.09 Clareway, Baltimore, MD 21214 22. MARK ADDRESS (Shored and Number or Rural Robus Number, Cay or Dam, State, Zip Codo) ACT (Shored Shored Shore	8										
The Malkanda no Practical of Miller Patricia Miller	BE										
PART II. Other significant conditions Due to (or as a consequence or)	2									_	
1 Burset 2 Commention 3 Removed from State Construction 5 Other (Specify) Septiment 2 Complete and Number of Health (Specify) 21. SIGNATURE OF PURISHAN. SERVICE LICENSES 1. SIGNATURE OF PURISHAN SERVICE LICENSES 1. SIGNATURE OF PURISH SERVICE LICENSES 1. SIGNATURE OF PURISH SERVICE LICENSES 1. SIGNATURE OF PURISH SERVICE LICENSES 1. SIGNATURE AND PURISH SERVICE LICENSES SERVICE LICENSES SERVICE LICENSES SERVICE LICENSES SERVICE 1. SIGNATURE AND PURISH SERVICE LICENSES SERVICE LICENSES SERVICE LICENSES SERVICE LICENSES SERVICE 1. SIGNATURE AND PURISH SERVICE PURISH SERVICE 1. SIGNATURE AND PURISH SERVICE LICENSES SERVICE 1. SIGNATURE AND PURISH SERVICE 1. SIGNATURE AND PURIS							_				
21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. PART LICENSE ALL HOME , P.A. 6009 Harford Rd. , Baltimore, MD 21214 23. PART LICENSE funeral states and baseline. 23. PART STATEMBURG FUNERAL HOME , P.A. 6009 Harford Rd. , Baltimore, MD 21214 24. PART STATEMBURG FUNERAL HOME , P.A. 6009 Harford Rd. , Baltimore, MD 21214 25. PART LICENSE (Finel disease or complications that passed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death of the passed of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death of the passed in the passed between Onset and Death of the passed interval Between Onset and Death of the De		1 N Buriet 2 Cremetton 3 Reme	oval from Stata	Db. PLACE AND DATE OF I	DISPOSITION (Ner	ne of	1				
ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214 23. PART 1. Enter the diseases, or complications that a part of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart, silver. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition) a				orerand Me			, ,			e, M	D
23. PART 1. Enter the disease, or complications that easily and astin. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or has fulfilled. List only one cavery or each line. Approximate intervel Between Onset and Deskind of the cause		1/1	01.0		ALTEN	BURG FUN	IERAL	HOME,	P.A.		
Interval Between Consett and Desth Consett and Destination			alling		6009 E	Harford	Rd.,	Balti	more,	MD	21214
No Due to (or as a consequence of):		shock, or heartyellure.	omplications that cause on	ed the death. Do not each line.	antar tha mod	de of dyling, aud	ch as card	lac or reapl	ratory arre	st,	Interval Between
Sequentially list conditions, if any, teading to immediate cause. Entar UNDERTYMD AND CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A C	!	disease or condition	Machia	1 obos	, ~						Onset and Death
Sequentially list conditions, if any, teading to immediate cause. Entar UNDERTYMD AND CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A C		resulting in death)	DUE TO (OR AS	A CONSEQUENCE OF):							-
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? PERFORMED? VES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? VES 2 NO 26. PLACE OF OEATH (Check only one) 27. MANNER OF OEATH 1 Neutral 5 Pending Investigation 3 Suicide a Could not be determined 28. OATE OF INJURY AT NOWN, Year Now, Year Suiding, etc. (Specify) 29. CERTIFIER 290. CERTIFIER 290. CERTIFIER 290. SIGNATURE AND ITILE OF CERTIFURG PHYSICIAN: To the basis of grammation end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner as attated. 290. SIGNATURE AND ITILE OF CERTIFURG. DATE OF DEATH (ITEM 27) (Type. Print) 31. DATE FILEO (Month, Day, Year) 21. Penn Street, Baltimore, Maryland 21201 32. REGISTRAR'S SIGNATURE	z										İ
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29e. CERTIFIER (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 29b. SIGNATURE AND TITLE OF CENTRIER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILEO (Month, Dey, Year) 32. REGISTRAR'S SIGNATURE 22e. PLACE OF INJURY — At home, farm, street, fectory, office 22f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 22e. PLACE OF INJURY — At home, farm, street, fectory, office 22f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 22e. PLACE OF INJURY — At home, farm, street, fectory, office 22f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 22e. PLACE OF INJURY — At home, farm, street, fectory, office 22f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 22e. PLACE OF INJURY — At home, farm, street, fectory, office 22f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 22e. PLACE OF INJURY — At home, farm, street, fectory, office 22e. PLACE OF INJURY — At home, farm, street, fectory, office 22f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 22e. LICENSE NUMBER 22e. LICENS					Y WOR	BK?	250. 023	CHIBE HOW II	WONT OCCU	HEO	
4 Homicide determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined City or Town, State) 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examplication end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CENTREER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201		2 Calebra	28e. PLACE OF INJUF	TY — At home, farm, stre			28f, LOCA	TION (Street a	ad Number of	Burel Bo	ita Number
29d. Date Signature and Title of Centherer 29d. Date Signature (Month, Day, Year) 30. Name and address of Person who completed cause of Death (ITEM 27) (Type, Print) 31. Date Filed (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 29d. Date Signat (Month, Day, Year) 70. C. M. E. Feb 13 1995 111 Penn Street, Baltimore, Maryland 21201		_ CODIO NOT DO	building, etc. (Spi	ecify)						THE THE	101100,
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David R Pauler 111 Penn Street, Baltimore, Maryland 21201	2	30 NAME AND ADDRESS OF DEDECKS WILL	COMBI EVED CALLOS CO.	FATAL STREET		O.C.N	4.E.		F	eb :	13 1995
31. DATE FILEO (Month, Day, Year) A 32. REGISTRAR'S SIGNATURE		David R Pa	Aler-			reet 1	Ral+	imore	Ma	r ₁ , 1 :	and 21201
HILLIAN TOTAL TOTAL CONTRACTOR PROGRAMMENT		FEB 1 5 1995		NATURE					, 110.	~ 7 .1.0	21201

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be made after that the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE

	REGISTRAN			PERIIL	ICATE	JE DEA	LH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Lest)						2	DATE OF DEATH			3. TIME OF DEATH
	Ea	r-L	M		Mars	h 50		ebruary 11,	1000	YEAR	5:29 AM
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER 1 YE		The second of the			A BIRTH	IPLACE (State or Foreign
	217-26-4098	1 💢 M 2 🗆 F	71	YRS.	MONTHS DA	YS HOURS	MIN.	Sept. 4,	1012	Countr	Virginia
	Se. FACILITY NAME (If not institution, give s				AL 0/7/ 70	WN OR LOCATI					
Œ			200+04				ON OF DEATI	Н		INTY OF D	EATH
2	Hopkins Bayview	mearcae (enier		ball	imore			N/i	A	
E E	10e. STATE 10b. COUNTY	,		10c. CIT	Y, TOWN OR L	DCATION					104 MINIST OUTV
뜻	Maryland N/A				ltimor					1	10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER			bu	CAUIION.						1 X YES 2 NO
₹ I						10f. ZIP COD					VHAT COUNTRY?
FUNERAL DIRECTOR	1002 Armistead W					2120	5		u.:	S.A.	
j.	11. MARITAL STATUS	12. WAS DECEDEN FORCES? 1	T.EVER IN U.S.	ARMED	13. WAS	DECENDENT	OF HISPANIC	ORIGIN? (Specify Yes	or No-	14. RACE	- American Indien,
BY I	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE W	AR OR DATES		1 1	YES 2 X NO	in, Mexican, F Specify:	verio Rican, atc.)		Speci	k, White, etc.
	3 25 Wildowed 4 Divorced	<u>ω</u> ω	orld Wa	r II			, ,		- 1	137150	White
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION COMPRISED	18e,	DECEDENT'S	USUAL OCCU	PATION		18b. KIND OF BUS	SINESS/IND	DUSTRY	
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5	+)	life. Do NOT us	e retired.)	g most of working	ng				
릴	N/A	N/Å	7	elevi	sion R	epairm	an	Repair	Shor	p	
0	17. FATHER'S NAME (First, Middle, Last)					18. MOT	HER'S NAME	(First, Middle, Maiden			
	Andrew Morris Ma	rsh						May Ray			
BE	19e, INFORMANT'S NAME (Type/Print)			105 MAII INC	10000000000				_		
임	Richard Marsh (B.	nathon	1					Number, City or Town			205
		tornet					ay, be	iltimore,			
	20e, METHOD OF DISPOSITION 1 (A Burlet 2 Cremation 3 Remains)	oval from State	gemetery,	E AND DATE (crematory or or	Per place)	N (Name of		OATE 20c. LO	CATION —	City or To	wn, State
	4 Donation 5 Other (Specify)		Garri	ison	rest	, MU V	et Cen	n 2/15 Ou	vings	Mil	ls, Md.
- 1	21. BIGNATURE OF FUNERAL SERVICE LIC	ENBEE			22. NAM	E AND ADDRE	SS OF FACILI	ial Home	-		
	1/1/1/19							re, Balti	maka	111	. 21213
\neg	23. PART i. Enter the diseases, or o	amplications the	A description of the control of the	Acids Di-							41213
	shock, or heert failure.	List only one cau	se on each li	ne.	ot enter the	mode or dy	ing, such s	s cardlec or respi	ratory sn	rest,	Approximate Interval Between
- {	IMMEDIATE CAUSE (Finel		,								Onset and Death
	disease or condition resulting in death)	. V-	-tack	~							
- 1		DUE TO	(OR AS A CONS	SEQUENCE OF):	_					
z		C	ME								
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate	DUE TO	(OR AS A CONS	EOUENCE OF):						
3	cause. Enter UNDERLYING	C	AD.								
Ē	CAUSE (Disesse or Injury that initiated events	QUE TO	OR AS A CONS	EQUENCE OF	ን:						
듄	resulting in death) LAST	. 1	172							-	
EDICAL	PART II. Other eignificant condition		death but no	t resulting i	n the under	ying ceuse (given in Par	t I. 24a. WAS AN		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
5	CRF C	VA						1 TYES 2			COMPLETION OF CAUSE
		/						, ' ' '	_ 140		OF DEATH?
Σ.	DID TOBACCO USE CONTI	RIBLITE TO CA	LISE OF DE	ATH YE	S D NO		ERTAIN				1 YES 2 NO
A	25. WAS CASE REFERRED TO MEDICAL	COULT TO CA			H (Check only		EKIAIIN				
PHYSICIAN:	EXAMINER?	HOSPITAL:			OTHER:	<i>y</i> 110)					
≥ I	1 TYES 2 NO	1 Napatient 2		1			sidence 8	Other (Specify)			
H	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF (Month, De	INJURY ny, Year)	28b, TIMI		INJURY AT WORK?	28	d. DESCRIBE HOW IN	YJURY OCC	CURED	
BY	2 Accident investigation				M: 1	YES 2	NO				
<u> </u>	3 Suicide 8 Could not be	28e. PLACE Of building.	F INJURY — At atc. (Specify)	home, farm, s	treet, fectory,	office	28	f. LOCATION (Street a	nd Number	or Rural A	oute Number,
	4 Homicide determined		, , , , , , , , , , , , , , , , , , , ,					City or Town, State)			
١٣	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of	my knowledge	death occurre	d at the time	data and alone		he cause(s) and man			
COMPLET	(Check only one) 2 MEDICAL EXAMINE										
8					n, ar my opinio	ii, desiii occoi	WG OF THE PARTY	e, date end place, end	u due to th	ie ceuse(s)	and menner se stated.
H :	296. SIGNATURE AND TITLE OF CERTIFIER					29c. LICE	NSE NUMBER	R	29d. OATI	E SIGNEO	(Month, Day, Year)
6	rapido, M.	ν_{\perp}				7 7	004		•	2/11	195
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUS	E OF DEATH (IT	EM 27) (Type,	Print)		4	1		1 6	
	CATPUAN MD JI	Mome	-,49	405	ASTE	en i	tre	Balto	o n	Up.	21224
	31. DATE FILED (Month, Day, Year)	32. REGISTRA				, , ,	1	0,,0,	1		
- 11	FEB 1 5 1995 Ju	led Daubles	Rardall								
- 1	1 0 1000 100										

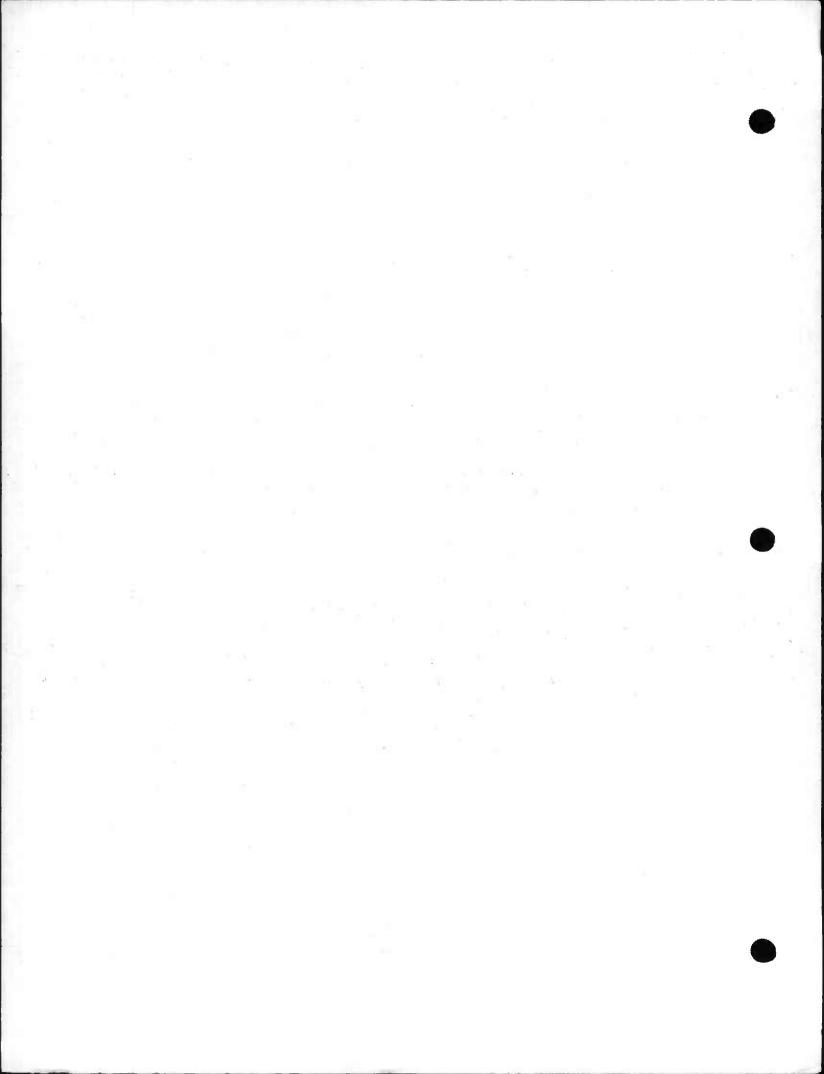


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Jour with death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be defined by use as the burish-transf permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burish, cremation, or remotal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

Olleged by Harry - Hed Exemmer ADS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	REGISTRAR		CERTIF	CATE U	DEATH	RE	G. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)	01110455		=		2. DATE OF DE	EATH DAY	YEAR	3. TIME OF DEATH
	MARYA MAR	GUARITE	MELA	NEY		2 - 5 - 9		TEAN	4 . 00A M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	7. DATE OF BI	RTH	8. BIRTHPI	LACE (State or Foreign
	200 14 3077	1 🗆 M 2 🖵 F	7 8 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day,		Country)	isulvania
	9e. FACILITY NAME (If not institution, give stre	et and number)	70	9b. CITY, TOWN	OR LOCATION OF	16-12-		INTY OF DEA	
Œ	Entit Waight	1.10.0110		D 0	timore				
읝	5011 Wright	Avenue		bax	LLMORE			n	a
Ä	10a. STATE 10b. COUNTY		10c. CIT	, TOWN OR LOC	ATION			1	IOd. INSIDE CITY
a	Maryland na		Rai	timor	0			Ι,	LIMITS?
اد	10e. STREET AND NUMBER		1500		of, ZtP CODE		10g, CI		IAT COUNTRY?
FUNERAL DIRECTOR	Entitude to				21205				
Z	5011 Wright Ave	12. WAS DECEDENT EVER I	IN II S ARMED	12 Whe D		ANIC ORIGIN? (Spe	-th- WN-	USI	
	1 Never Merried 2 Married	FORCES? 1 YES	2 NO	If yea,	specify Cuben, Mex	cen, Puerto Ricen,		Black,	- American Indian, White, etc.
B	3 Wildowed 4 Divorced	NO	DATES	1 U Y	S 2 NO Spe	cify:		Specify:	white
0	15. OECEDENT'S EDUCA	TION	18e. DECEDENT'S	USUAL OCCUPAT	TION	18h KIND	OF BUSINESS/IN	DUSTRY	while
E	(Specify only highest grade co		(Give kind of v	vork done durina i	nost of working				
P	8	College (1-4 or 5 +)	Soci	al Sec	uritu	F	ederal	Gov	't
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					NAME (First, Middle,	Maiden Sumernel		
	Peter Rendzio	ı b			Anna	Cwyk	maiden Sumame)		
BE	19e. INFORMANT'S NAME (Type/Print)								
2	Sandra Gorrera					nue, Bal			
	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remov		b. PLACE AND DATE (metery, crematory or o		Name of	DATE	20c. LOCATION -	- City or Town	n, State
	4 ☑ Donetion 5 ☐ Other (Specify)								
	21. SIGNATURE OF FUNERAL SERVICE LICE	Rongeld	wade, Di	た 22. NAME	AND ADDRESS OF	FACILITY S	tate A	nator	ny Board
	would o. to	a Kint	•	655W	.Baltin	iore St	,Balto	, MD21	1201
1	23. PART I. Enter the diseases, or co	mplications that causa	d tha death. Do r	ot anter the n	oda of dylng, a	ich aa cardlac o	r reapiratory a	rreat,	Approximata
	ahock, Dr haart failure. Li	st Dnly Dne cause Dn a	ach ilne.		140				interval Between
1	iMMEDIATE CAUSE (Final disease or condition	(preba	O MACO	Osto.	oschotic	· ()-			Onset and Death
	resulting in death) a.		A CONSEQUENCE OF		OSLUCIJ 10	ices.			101 Ap
_		KL.	Mo To	0.00					i "
CERTIFICATION	Sequentially list conditions, b.	DUE TO OR AS	CONSEQUENCE OF	7:					
AT	if any, leading to immediate cause. Entar UNDERLYING	2.000	to Settlement	,					j
띮	CAUSE (Disease or injury that initiated evants	DUE TO (OR AS	A CONSEQUENCE OF	·);					
E	resulting in death) LAST								1
R	d.								
	PART II. Other aignificant conditions			n the undariy	ng cauae given	in Part i. 24a.	WAS AN AUTOPSY PERFORMEO?		VERE AUTOPSY FINDINGS
EDICAL		non All	len St	sease	7		YES 2 NO		WAILABLE PRIOR TO COMPLETION OF CAUSE
						' ' '	(- 1	OF DEATH?
. M									
₹	25. WAS CASE REFERRED TO MEDICAL			28.	PLACE OF DEATH (Check only one)			
25		HOSPITAL:	netlant 3 1 DOA	OTHER:	-		M. A.		
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIM		JURY AT	a Other (Spec	E HOW INJURY OF	CUBED	
	1 Natural 5 Pending	(Month, Day, Year)	INJ	URY	YES 2 NO	200. DESCRIBE	. HOW INSONT O	CONED	
B	2 Accident Investigation 3 Suicide 8 Could and be	28e. PLACE OF INJUR	V — At home term (201 1 00471011	(Street and Number		
	4 Homicide 8 Could not be determined	building, etc. (Spe	ecify)	ineet, lectory, or		City or Tow		er or nurei noi	ule Number,
<u> </u>	200 CENTIFIED TO								
린		AN: To the best of my know							
COMPLETE	2 MEDICAL EXAMINER:	On the besis of examination	on end/or investigation	n, in my opinion	death occured at t	he time, date and p	elece, end due to t	the ceuse(s)	end menner es atated.
w II	29b. SIGNATURE AND TITLE OF CERTIFIER	٨	1 , 1		29c. LICENSE N	UMBER) 29d. DA	TE SIGNED (I	Month Day, Year)
0	Medene	X 110 - 1	(ll)		()0	7511	/ • ·	7-1-	7/95
U 11		1 19/14/					9		
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type,	Print)				-	113
F		- Company	710		7 Augni	o Ralt	imoro	MD	1.73
۴	30. NAME AND ADDRESS OF PERSON WHO OR THEODORE 31. DATE FILED (Month, Day, Year)	- Company	2801		r Aveni	ie, Balt	imore,	MD	7.73
Ţ	DR THEODORE I	VIZNIK	2801 NATURE		r Aveni	ie, Balt	imore,	MD	1



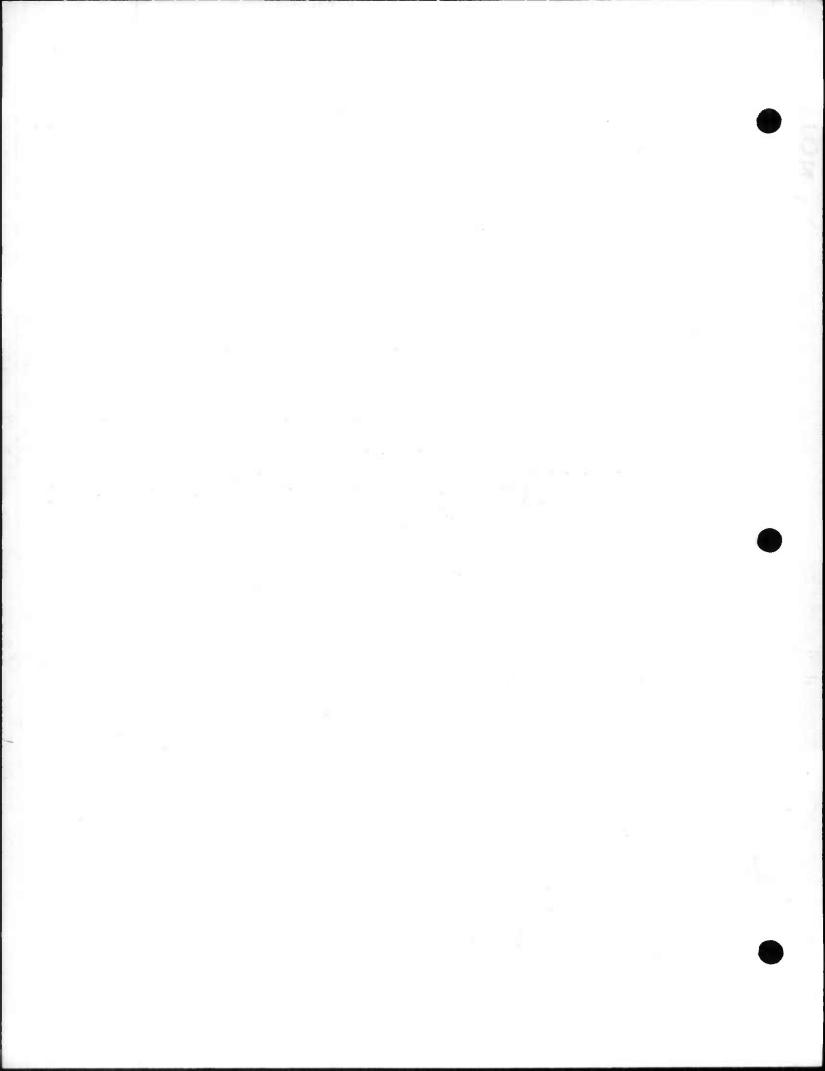
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1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

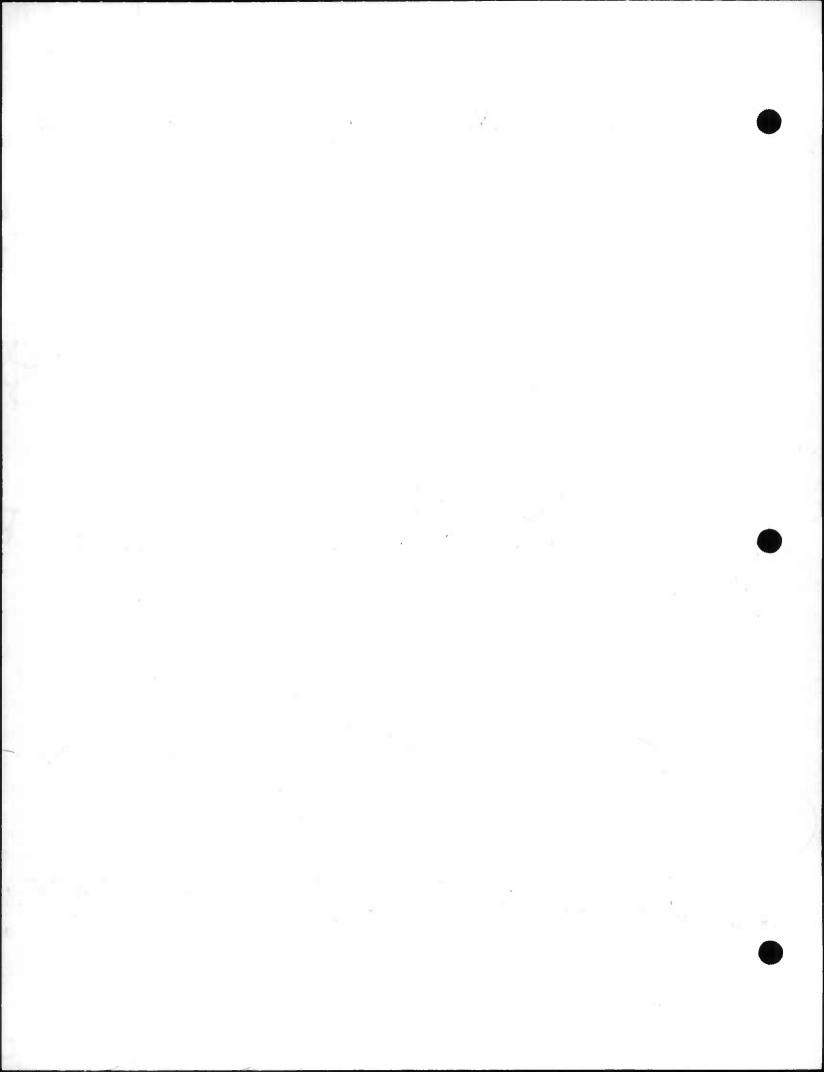
		Tae Im Na	t, Middle, Last)									2. DATE OF	3-95 th	NY	YEAR	3. TIME OF DEATH 7:20 a.m.
_		4. SOCIAL SECURITY NUM 213-21-2088		5. SEX	8. AGE (II	n yrs. lesi	YRS.	IF UNDE	DAYS	IF UNDER	R 24 HRS.	7. DATE OF (Month, 10 - 1	BIRTH Day, Year) 0-10		Count	IPLACE (State or Foreign ry) Yea
3 should	E E	9a. FACILITY NAME (If not it								OR LOCATI	ION OF DE			9c. COUN	ITY OF 0	EATH
1, 2,	5	10100 Bals	CEDENT	d Drive Laurel Pri								Prii	ice	George		
it. Pages	DIRECTOR	Maryland	Princ	v e George				v. town urel	OR LOCA	TION						10d. INSIDE CITY LIMITS?
permit.	IAL	10. STREET AND NUMBER								H. ZIP COD	E			10g. CITI	WHAT COUNTRY?	
an. ransit	FUNERAL	10100 Bals	amwood						, ,	20 <mark>7</mark> 08	}			Ko	rea	
5-0020 nding physician.	BY FU	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Div		12. WAS DECEDED FORCES? IF YES, GIVE 1	1 YES	2 A N	MED O	13.	If yes, sp	pecify Cube		C ORIGIN? (, Puarto Ric		or No—	14. RACI Blaci Spec	E — American Indian, k, White, atc. Hy: Asian
215-0 r attending use as the	E		CEDENT'S EDU				CEDENT'S					16b. K	IND OF BUS	SINESS/IND	USTRY	
for u	PLET	Elementary/Secondary (College (1-4 or 5	+)	Ma.	ema k	te retired.)	auring m	ost of worki	ng	Но	me			
Z ge S	COMP	17. FATHER'S NAME (First, A	Aiddle, Last)			110111	Cina it			18. MOT	HER'S NAM	IE (First, Mid		Surname)	_	
इ दूर	ш	(UNK) Mean	g								(UNK					
retained 5 should notified	TO B	19a. INFORMANT'S NAME (Type/Print)									oute Number,				
RE, N ay be re page 5	-	Song Ku Na				10	100	Bals	amw	ood D)rive	, Lau	rel,	Mary	land	20708
e 6 m rector,		20e, METHOD OF DISPOSITION SDBurlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Cemetery Dorsey, Man									C. C. C. C. C. C. C. C. C. C. C. C. C. C					
ALTIN death. Pag e funeral dis i. examiner	-	21. SIGNATURE OF EUNERA	AL SERVICE LIC	CENTRE	6	2		22.	NAME A	ND ADDRE	ss of FAC	Home	. Inc			
BAL Ber dear the fun val.		V 0	Lall	1 NO	30C	4									1. M	ld. 20707
tely fill mation.		23. PART I. Enter the d ahock, or h IMMEDIATE CAUSE (Fi disease or condition resulting in death)	eart tallum.	List only one car	OR AS A	ch line	1						c or respl	ratory arm	est,	Approximata Interval Betwee Onset and Deat
F.O. BOX 68 ith certificate be executeding physician and all Hygiene prior to bur or other traumatiful.	ERTIFICATION	Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or inju- that initiated events resulting in death) LAS	diate ING ury	с	OCAS A	CONSEC	OENGE OF	·		etz	ola	79.				
at the death by the atter and Mental y Injury, o	L C	PART II. Other significa	ant condition	a contributing to	death bu	it not re	aulting I	n the u	nderlyin	g cause (given in F	Part I. 24	la. WAS AN	AUTOPSY	24b	. WERE AUTOPSY FINDINGS
requires that the been signed by the state and shows any in	MEDICAL		lity										PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
SICIAN: The law requestificate has been the State Dept. of the 23 sho		DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF	DEAT	TH YE	s 🗆	NO 🗵	UNC	ERTAIN					1 TYES 2 NO
V: The law icate has State Dept	SICIAN:	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:	2	6. PLACI	OF DEAT									
CIAN: T CIAN: T srtificate the State	YSI	1 TYES 2 NO		1 Inpatient 2		rtlent 3	□ DOA	4 Nu	Rt: rsing Horr	ne 5 Re	ealdence (Other (S	(pecify)			
The state of the control of the cont	ВУ РНУ		Pending Investigation	28e. DATE OF (Month, E			28b. TIMI	E OF URY M	WC	ORK? YES 2		26d. OEŞCR	BE HOW IN	JURY OCC	URED	
TTENDI TOR: A after d		3 Suicide 6	Could not be determined	28e. PLACE C building,	of INJURY -	— At hon	ne, ferm, s	treet, fac	tory, offic	:•			ON (Street e fown, State)	nd Number (or Rural F	loute Number,
RAL DIR	COMPLETED			CIAN: To the best of) and manner as stated.
FUNE FUNE WITHIN	- 11	29b. SIGNATURE AND TITLE									ENSE NUMI		1			
THE PLINE THE PL	BE	ZLK	26.1	Dem						7	1/ic	100		AND DATE	> /	(Month, Day, Year)
-//	임	30. NAME AND ADDRESS OF	F PERSON WH	O COMPLETEO CAU	SE OF OEA	TH (ITEM	27) (Туре,	Print)			14-7	07			-//	2074
		31. DATE FILED (Month, Day,	4. Yo	W. MD.	730	-	BA	TI	MOR	E 7	AUE	#1	11 . (all	lege	fack Me
_			- 11	· 144	Part 1	M.										

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



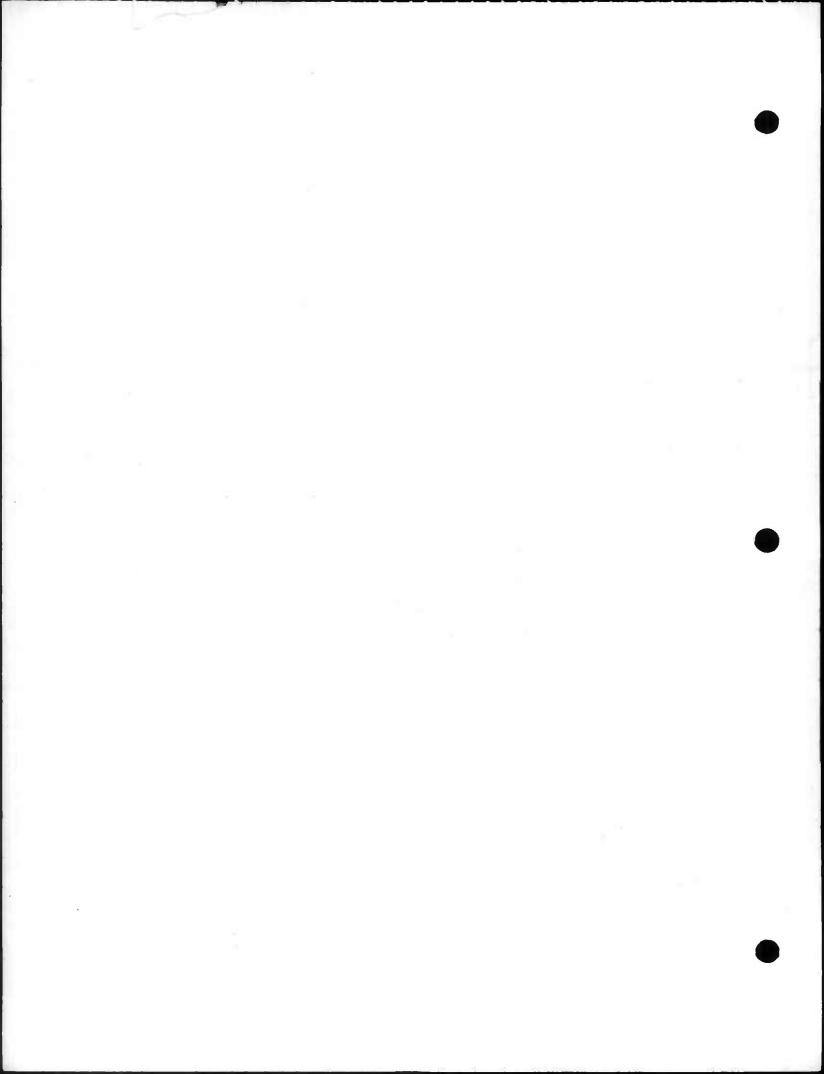
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	FOR STATE REGISTRAR	STATE OF MARYLAN	ND / DEPART	TMENT CATE	OF H	EALTH DEAT	AND N	MENTAL	HYGIEN REG. NO			
	1. DECEDENT'S NAME (Erst. Middle, Last) Don ald	N.	New	ber	16	×	9	2. DATE OF MONTH			Z S	3. TIME OF DEATH - 132 A M
	212-64-8392	№ 2 F	yrs. last birthday) 42 YRS.	IF UNDER 1	DAYS	IF UNDER HOURS	MIN.	SEPT.	F BIRT/1 Day; - War) 23, 19	-	Country	PLACE (State or Foreign) HINGTON, DC
TOR	Sa. FACILITY NAME (If not institution, give street LAUREL REGIONAL HOSPITA RESIDENCE OF DECEDENT			9b. CITY,	TOWN O	LAU		ATH		PR I NO		
DIRECTOR)WARD	10c, CITY	, TOWN OF	R LOCAT	LAU	REL					10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	9528 OLD LANTERN WAY				10f.	ZIP CODE				10g. CITIZE USA		HAT COUNTRY?
3 Wildowed 4 Divorced IF YES, OIVE WAR OR DATES 1 YES 2 NO Specify: WHIT									White, etc.			
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12) 12 4		(Give kind of we life. Do NOT use ENG I NEEF	ork done du retired.)	CUPATIO uring mos	N st of workin	9			TRANSPO		ION, MO. CO.
SO	17. FATHER'S NAME (First, Middle, Last)					18. MOTH	ER'S NAM		ddie, Maiden			
BE	DONALD N. NEWBERRY, SR. 19a. INFORMANT'S NAME (Type/Print)						E LEG					
임	KATHLEEN A. NEWBERRY		9528 OL								ode)	
	20a. METHOD OF DISPOSITION 1 CyBurlet 2 Cremetion 3 Removal 4 Donation 5 Other (Specify)	t from State 20b. PL cemete	ACE AND DATE OF	F DISPOSIT	TION (Nat			0ATE	20c. LO	CATION - CH		,
1	21. SIGNATURE OF FUNEBAL SERVICE LICENS		0	22. N	AME AN	D ADDRES	S OF FAC	FL	ECK FU	NERAL H	IOME.	INC.
	/ atal	gua	Øy_	/6	o01 S	ANDY	SPRIN	IG ROAL	, LAUR	EL, MAR	RYLAN	D 20707
ATION	23. PART . Enter the diseases, or dom shock, or heart failure. The immediate cause or condition resulting in death) Sequentielly list conditions, if sny, leeding to immediate cause. Enter UNDERLYING	Tens selled to the to the to the to the to the to the to the to the total to the total total to the total to	DISEQUENCE OF	ad				_			it,	Approximate Interval Between Onset and Daath
CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST	OUE TO (OR AS A CO	DNSEQUENCE OF)	*								
¥	PART II. Other significant conditions c	ontributing to death but	not resulting in	the und	eriying	cause g	iven in P		4a. WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH YES	Пи	O F	UNC	ERTAIN					1 TES 2 NO
CIA	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH	Check on	ily one)							
KS		☐ Inpetiant 2 ☐ ER/Outpetie	nt 3 00A		ng Home	_	idence 8	Other (Specify)			
	1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b, TIME INJU	OF 2	8c. INJU WOR		- 1	28d. DESC	RIBE HOW II	JURY OCCUI	RED	
TED BY	2 Accident Investigation 3 Suicide 8 Could not be datermined	28a. PLACE OF INJURY — building, atc. (Specify)	At home, farm, st	reat, factor			-	281. LOCAT City or	ION (Street a Town, State)	nd Number or	Rural Ro	ute Number,
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN 2 MEDICAL EXAMINER: 0	N: To the best of my knowledge on the besis of examination ar									:ause(a)	and manner as stated.
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 30. MANE AND ADDRESS OF REFEREND WHO CO	disce z	MD		1	Oc. LICE	JS NUME	BER	1	Tod. DATE S	ONED (Month, Day, Year)
	FILEUS DI B des	OMPLETED CAUSE OF DEATH ALL ALL ASS. REGISTRACE SIGNATURE	507 9	Ray	bi	דודעו	CH.	Cp	Spr	2. M	1-	10748
	FEB 1 5 1995 Julia 6	Two sor Kartall							e#			-



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FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MONTH D YEAR IZA 3:45 Ax SON 10-95 6. AGE (In yrs. last birthday) 5. SEX 7. DATE OF BIRTH (Month, Day, Irea IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign Country) (Month, E 68 1 M 2 MF YRS M ter death. Page 6 may be retained by the hospital or attending physician. the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Balto DIRECTOR NUTSING ANOF RESIDENCE OF DEC 10a STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Bal 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U,5,7 14 1202 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YNO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yea, specify Cuban, Mexicen, Puerto Rican, etc.) 1 YES 2 NO Specify: 14. RACE — American Indien, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Merried 2 Merried BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 9 JAM notified at once. 17. FATHER'S NAME (First, Middle, Last) BE 19e. INFORMANT'S NAME (Type/Print) 2 be 20s. METHOD OF DISPOSITION 206. PLACE AND DATE OF DISPOSITIONANA DATE must 1 Buriel 2 Cremation 3 Ra
4 Donellon 5 Other (Specify) medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY executed within 24 hours after death. De 23. PART 1. Enter the disease, or complications that caused the deeth. Do not enter filled in by t the mode of dying, such as cardiec or respiratory arrest, Approximete ahock, or heart feilure. List only one cause on each line. Intervel Between HE PATIC IMMEDIATE CAUSE (Finel **Onaat and Death** other traumatic event, the disease or condition cremation. completely recuiting in death) DUE TO (OR AS A CONSEQUENCE OF): burlal. CERTIFICATION and Sequentielly list conditions, 2 If any, leading to immediate cause, Enter UNDERLYING prior eath certificate CAUSE (Disease or Injury that initiated events attending resulting in deeth) LAST 0 the atten shows any injury, PART II. Other aignificent conditione contributing to death but not resulting in the underlying ceuse given in Pert i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS sugned by the OCOCCU PERFORMED? AWAILABLE PRIOR TO COMPLETION OF CAUSE MOKON. 1 YES 2 NO has been DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES NO UNCERTAIN Dept Item 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one **EXAMINER?** I DYES DE OTHER: 1 Department 2 ER/Outpatient 3 DOA ng Home 5 - Residence 8 - Other (Specify) # 6 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT this , 28d. DESCRIBE HOW INJURY OCCURED marked. to Natural 1 YES 2 NO 2 Abeldent ₽¥ 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28t. LOCATION (Street end Number or Rural Route Number, City or Town, State) 17 3 Suittide COMPLETED 8 Could not be DIRECTOR affe 28 4 Nomicide Hem 29s. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date end place, end due to the cause(s) and manner es stated. TO THE FUNERAL DO THE FUNERAL DO THE FUNERAL DI MPÓSTANT. IT IN 2 ___ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the lime, data and place, and due to the cause(s) and manner as stated. 296. MONATURE AND TITLE OF DESTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 41980 (JUNOUD Verans, MJC. 12/1019J NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NICHST. BSITO, MOZI MACHER HES ITH 2700 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Davidson Randall 5 1995



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within as hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)	Florence	Claire	O'Nei		2. DATE OF DEATH		3. TIME OF DEATH
	Florence C	O'NEILL				2-4-9		el:50PM
		SEX S. AGE (In)		F UNDER 1 YEAR	IF UNDER 24 HAS.	7. DATE OF BIRTH (Month, Day, Year)	6. 1	BIRTHPLACE (State or Foreign Country)
	90. FACILITY NAME (If not institution, give stree					11-07-11		Ew Jersey
E .		irs & Rehal		Chost	ertown	EATH	9c. COUNTY	OF DEATH
18	RESIDENCE OF DECEDENT	- Total	o chic	Chest	- CALOWN		Kent	
DIRECTOR	Maryland Kent	Co		TOWN OR LOCATIO				10d. INSIDE CITY LIMITS?
	10e, STREET AND NUMBER			Cheste	TTOWN			1 YES 2 NO
I A	Chestertown Nur	rs Home & 1	Rehab C		LIF CODE	21620	10g. CITIZEN	OF WHAT COUNTRY? USA
FUNERAL	11. MARITAL STATUS	2. WAS DECEDENT EVER IN U	.S. ARMED	13. WAS DECE	NDENT OF HISPAN	IIC ORIGIN? (Specify Yes	or No— 14.	RACE — American Indian.
BY F	1XNever Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES	S		Ify Cuban, Mexice NO Specify	n, Puerlo Ricen, etc.)		Black, White, etc. Specify:
ED B	15. DECEDENT'S EDUCAT	TON 1	NO	IIAL OCCUPATION		Las vinin on au		White
13	(Specify only highest grade cor	mpleted) College (1-4 or 5+)	(Give kind of work life. Do NOT use n	k done during most etired.)	of working	16b. KIND OF BUS		RY
실	12 +	20/10/20 (1-4 0/ 0+)	Nurse	's Aid	e	Medic	cine	
COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)	
H	John O'Neill 190. INFORMANT'S NAME (Type/Print)					aret Mc		
2	Terri Sanders	0.10				Route Number, City or Town		,
	20e. METHOD OF DISPOSITION	20b. PL	ACEAND DATE OF I			e Cheste	<u> たたのいれ</u> CATION — City	
	1 Buriei 2 Cremetion 3 Remova 4 D Donation 5 Other (Specify)	of from State cemete	ry, cremetory or other	place)				
	21. SIGNATURE OF FUNERAL SERVICE LICEN	see Ronald Wa	ide, Dir	22. NAME AND	ADDRESS OF FAC	CILITY State	Anat	omy Board
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE RONald Wade, Dir 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD21201							MD21201
	23. PART i. Enter the diseeses, or con ehock, or heert fellure. Lie	npilicetions thet caused the	he death. Do not	enter the mode	of dying, such	h ae cerdiac or respi	ratory erreet,	
	IMMEDIATE CAUSE (Finei					0 1		interval Between Onset and Desth
-	disease or condition resulting in death)	end stag	e cons	estive	hear	+ failure		
-	disease or condition resulting in death) a. end stage congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): J							
101	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):							
ICA	CAUSE (Disease or injury C. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.								
	d							
NA I	PART il. Other eignificant conditions of	1		the underlying	cause givan in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
PHYSICIAN: MEDIC	COPONARY AF	tery disees	2			1 YES 2	S.HO.	OF DEATH?
Σ	DID TOBACCO USE CONTRIB	LITE TO CALISE OF	DEATH VEC		LINICEDTAIN			1 YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH		UNCERIAII	ч Ц		
Sic		OSPITAL: Inpatient 2 ER/Outpatie	ent 3 DOA 4	THEB	5 Residence	6 Other (Specify)		
E	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME O		RY AT	26d. DESCRIBE HOW IF	NJURY OCCURE	D
B	1 Natural 5 Pending 2 Accident investigation			M 1 TYE	S 2 NO			
	3 Sutctde 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, ferm, atre-	et, factory, office		28f. LOCATION (Street e City or Town, State)	and Number or R	tural Route Number,
9	29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge death occurred at the time date and close and due to the grant of the same of the s							
COMPLETED	206. CERTIFFING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es atated. (Check only one) 2 MEDICAL EXAMINER: On the best of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner es atated.							
	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)							
m. hy 1235/4 2-6-8								
임	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEATH	(ITEM 27) (Type, Pri	nt)				
	21 DATE SHED (March Day March	Las projections						
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATU						
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

MG PHYS fler this c eath with marked,	JING PHYSICIAN: The law requires that the death certificate be executed within, 24 hours after death. Page 6 may be retained by the hospital or attending physician.	1. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3.	death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notitled at once.
	ICIAN: The law	ertificate has t	the State Dept.	or Item 23
	OR ATTEN	MRECTOR	ours after	ет 28 ∣
NA ATTEI MRECTOR MIS after	SPITAL C	VERAL D	nin 72 hc	VT: It IN
AL OR ATTER AL DIRECTOR 2 hours after It Item 28	TO THE HO.	TO THE FUNERA	be filed with	IMPORTA

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH AGNES POPE 7. DATE OF BIRTH
(Month, Day, Year)
03-13-37 1/20 AM 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreig IF UNDER 24 HRS. · Carolina HOURS 217-34-7989 1 M 2 TF 57 YRS. N. 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Sinai Hospital Baltimore RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY maryland Baltimore YES 2 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2510 Oakley Ave. 21215 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 TNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE - American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, stc.) 1 TYES 2 NO BY Specify: Specify: Black 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 4 Domestic Household 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sidney Pope Henrietta Baines BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Sylvester Cash 5024 Pembridge Ave. Balto., Md. 21215 20a. METHOD OF DISPOSITION
XIXBurial 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State melary, cremajory or other place)
Druid Ridge Cemetery2+13-95 4 Donation 5 Other (Specify) Balto., Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Leroy O. Dyett& son Funeral Home Inc 4600 Liberty Heights Ave. 21207 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Betw IMMEDIATE CAUSE (Finel Onset and Death disease or condition Breast Metastalic resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Effusion eur4/ CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF) Myeloma cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events DUE TO (OR AS A CONSEQUENCE OF) resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square N N 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:
1 inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending BY 1 YES 2 NO 2 Accident 26a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide determined 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 8

COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTRAR'S SONATURE

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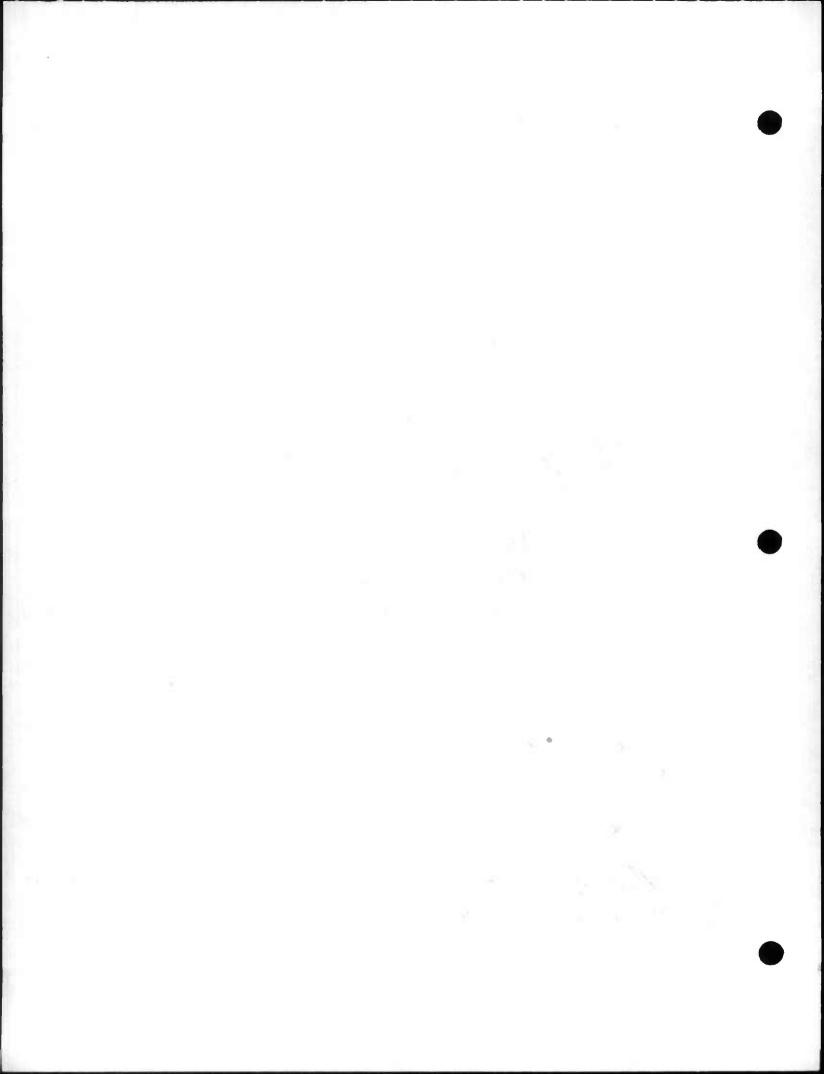
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31. DATE FILEO (Month, Day, Ybar)

Item # 19b,19a Film # G 720 2-15-95 N.A. Per funeral home STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE CERTIFICATE OF DEATH 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR 5130 CHARLES **EDWARD** PRESBERRY, Sr. FebruRy 1995 4. SOCIAL SECURITY NUMBER 5. SEX B. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 1 😾 M 2 🗌 F YRS. 214-24-5379 June 16 1930 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWH OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 905 Andover Road Baltimore 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Georgia Atlanta 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 275 Scenic View Court South WEst USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 □ NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ВY 1 YES 2 NO Specify: Specify: 3 Widowed 4 Divorced Black 18e. DECEDENT'S USUAL OCCUPATION ETED 15. DECEOENT'S EDUCATION 16b. KIND OF BUSINESS/INQUISTRY (Specify only highest grade completed) (Give kind of work done life. Oo NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL College E.D. Specialist Federal Government 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) ĕ 8 Isabelle Robinson notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Margie Young 905 Andover Road Baltimore, Maryland 21218 pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must Feb₁d Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD Veteran Cemetrey/Garrison Owings Mills, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADORESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216 medical 23. PART I. Enter the diseasee, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or reapiratory arrest, Approximata shock, or heart fellure. List only one cause on each line. Interval Batween IMMEDIATE CAUSE (Final Onset and Death 유 diseese or condition Kewal Frelune weeks resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF) Diplactes raumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING Herpertension CAUSE (Diseese or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST Injury, PART II. Other significent conditione contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINOINGS AVAILABLE PRIOR TO CEREGROUSSCURION RECIDENT any COMPLETION OF CAUSE 1 YES 2 HOT OF DEATH? Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 - Nursing Home 5 Residence 6 - Other (Specify) 6 26a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d, OESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO B Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 98 COMPLETED a Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end manner es stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. TO THE H TO THE FU De fled with 296. SIGNATULY AND VILLE OF SENTIFIC

Coleman, mo

29d. DATE SIGNED (Month, Day, Year)

2-8-85

29c. LICENSE NUMBER

1)22857

32. REGISTRAR'S SIGNATURE

38. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Brint)



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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within actions after death. Page 6 may be retained by the hospital or attending physician.

TO THE HIGHAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be activated the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

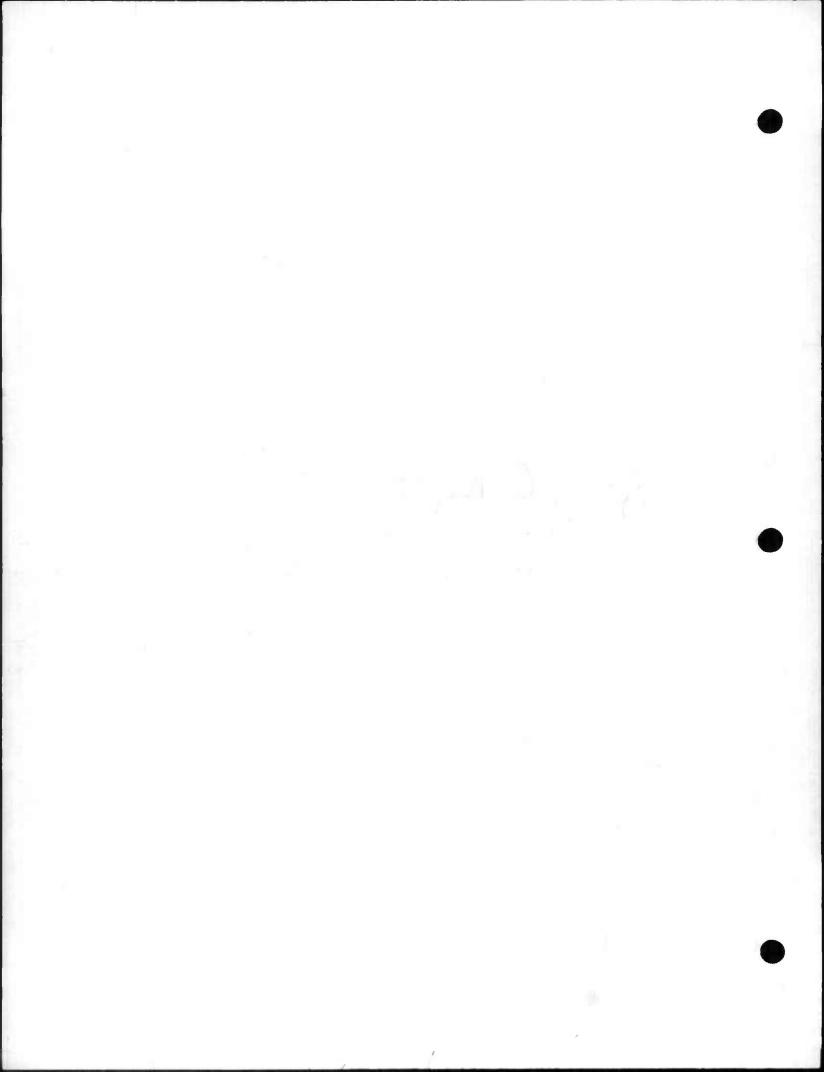
31. DATE FILED (Month, Day, Year)

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MEN CERTIFICATE OF DEATH	NTAL HYGIENE REG. NO.						
		DATE OF DEATH	3. TIME OF DEATH					
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. list birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. E	EB 11 199	5 9:12 A.M					
	214-26-3/289 1 M 2 OF 65 YRS. MONTHS DAYS HOURS MIN.	DATE OF BIRTH (Month, Day, Year) AN 30, 1930	BIRTHPLACE (State or Foreign Country)					
e e	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH 9c. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNT	Y OF DEATH					
딥	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY					
- DIRECTOR	MD. BALTIMORE	·	LIMITS?					
FUNERAL	104. STREET AND NUMBER 107. ZIP CODE 101. ZIP CODE 21202	10g. CITIZE	N OF WHAT COUNTRY?					
E	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMDENT OF HISPANIC O 1 Never Married 2 Married 12. WAS DECEMDENT OF HISPANIC O 13. WAS DECEMDENT OF HISPANIC O 14. WAS DECEMDENT OF HISPANIC O 15. WAS DECEMDENT OF HISPANIC O 16. WAS DECEMDENT OF HISPANIC O 17. WAS DECEMDENT OF HISPANIC O 18. WAS DECEMDENT OF HISPANIC O 19. WAS DECEMDENT OF HISPANIC O 19. WAS DECEMDENT OF HISPANIC O 19. WAS DECEMDENT OF HISPANIC O 10. WAS DECEMDENT OF HISPANIC O 11. WAS DECEMDENT OF HISPANIC O 11. WAS DECEMDENT OF HISPANIC O 12. WAS DECEMDENT OF HISPANIC O 13. WAS DECEMDENT OF HISPANIC O 14. WAS DECEMDENT OF HISPANIC O 15. WAS DECEMDENT OF HISPANIC O 16. WAS DECEMDENT OF HISPANIC O 17. WAS DECEMDENT OF HISPANIC O 18. WAS DECEMDENT OF HISPANIC O 19. WAS DECEMBENT OF HISPANIC O 19. WAS DECEMBE		Bleck, White, atc.					
B	3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify:		Specify: WHITE					
TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUS	STRY					
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5 +) SECRETARY	CITY GO	VERNMENT					
5	17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (F	First, Middle, Malden Surname)						
BE	POCCO DIFIETRO 199_ANFORMANT'S NAME (Type/Pjal) 190. MAILING ADDRESS (Street and Number or Bursi Route		2NO					
TO BE COM	RICHARD PRAGLOWSKI 353 TERNWING	CT. ARNOL	D 21012 MD.					
T T T T T T T T T T T T T T T T T T T	20a. MSTHOD OF DISPOSITION 10 Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Compaction o							
gygumen	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	SONS FUNE	nc Home					
	Brulf Nelle 100 322 S. Hich	STI BALTO	2/202 Md.					
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as ehock, or heart failure. List pnly one cause on each line.	cardlec or respiratory srres	t, Approximate interval Batween					
	IMMEDIATE CAUSE (Finel disease pr condition Me La of- 4		Onset and Death					
, and a	disease or condition reculting in deeth) a. Metastatic Adeno corcuro mo pue to (or as a consequence of:	of Lun	9					
	Sequentially list conditions b.							
CERTIFICATION	Sequentielly list conditions, If smy, leeding to immediate cause. Enter UNDERLYING							
TIFIC	CAUSE (Disease Dr injury thet initieted events Due TO (OR AS A CONSEQUENCE OF):							
ERT	resulting in deeth) LAST							
3	PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part	i. 24a. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS					
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N N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN							
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:							
14S	1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Maaidence 8 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 26c. INJURY AT 26d	Other (Specify) DESCRIBE HOW INJURY OCCUP	250					
BY PP	11 Netural 5 Pending (Month, Day, Year) INJURY WORK? M 1 YES 2 NO	. DESCRIBE NOW INJURY OCCUP	ACD .					
	3 Suicida 8 Could not be 28e. PLACE OF INJURY — At home, farm, atreet, factory, oHica building, atc. (Specify)	LOCATION (Street and Number or City or Town, State)	Rural Route Number,					
ETED	4 Homicide detarmined	only or lown, state)						
COMP	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the one) 2 MEDICAL EXAMINER: On the best of axamination and/or investigation, in my opinion, death occurred at the time,		ause(a) and manner as stated.					
	296. BILLION AND TIME OF CERTIFIER # TT Z VI JIM 290. LICENSE NUMBER	29d. DATE S	IGNED (Month, Day, Year)					
E W	Class Com B PHYSICEAN D306:		IGNED (Month, Day, Year)					
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (See Origin)		BALZO MA					

HOSPINE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

TO EMORPHYL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the blooming physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be mind within the State Dept, of Health and Memal Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last)	CERTIFICATE OF BEAT				2. DATE OF DEATH 3. TIME OF DEATH			
i i	CAROLYN T	ROLAN	ID			FEBRUARY 11,	1995	1:00 Pm	
1		S. SEX 6. AGE (In		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTI	HPLACE (State or Foreign	
- 3	220–20–6137	□ w 2XC F 67	YRS.	ONTHS DAYS	HOURS MIN.	4/27/27	Ba1	to., Md.	
1	9e. FACILITY NAME (If not institution, give street	t and number)		96. CITY, TOWN	OR LOCATION OF D		COUNTY OF E		
DIRECTOR	THE JOHNS HOPKINS	HOSPITAL		BALTIMO	ORE CITY				
EC	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCA	TION			10d, INSIDE CITY	
	Maryland		Ва	altimo	re			LIMITS?	
FUNERAL	10e. STREET AND NUMBER			10	. ZIP CODE			WHAT COUNTRY?	
NE	916 Pennsylvania			21201				USA	
F	11. MARITAL STATUS 12 1 Never Married 2 Merried	 WAS DECEDENT EVER IN L FORCES? 1 YES 					14. RACE — American Indian, Black, White, etc.		
BY	3€ Widowed 4 Divorced IF YES, GIVE WAR OR DATES				2X NO Specific		Specify: Black		
	15. DECEDENT'S EDUCATI	ION 1	ISa. DECEDENT'S U	SUAL OCCUPATION	ON	16b. KIND OF BUSINES	S/INDUSTRY	DIACK	
E .	(Specify only highest grade con Elementary/Secondary (0-12)	mpleted) College (1-4 or 5 +)		rk done during mo		THE RIFE OF BOOMES	SAMOOSTAT		
F F	12th		Hous	sewife		N	/A		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Maiden Surne	me)		
BE	Moses L. Thomas	S			Helen	a Marie Bu	tler		
10	19e. INFORMANT'S NAME (Type/Print)		196. MAILING A	DDRESS (Street e	nd Number or Rural	Route Number, City or Town, Sta	te, Zip Code)		
F	Wanda Crutchfie	1d	725 N	4ilyer	Lane	Baltimore,	Md.	21229	
	20a. METHOD OF DISPOSITION 17 Burlel 2 Cremellon 3 Removal	from State	LACEANDDATEOF	DISPOSITION (Na	me of 2/15	DATE 20c. LOCATIO	N — City or To		
	4 Donation B Other (Specify)	→Ba	Trematory or other	Nati	onal Ce	m. Laur	el, M	aryland	
	21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY I.EROY O. DYETT & SON FUNERAL HOME								
	Nonal	C. NO				Y HEIGHTS			
	23. PARTA. Eater the diseases, or com	splications that caused f	death. Do not	t enter the mo	de of dying, suc	h ea cardiac or respirator	y arrest,	Approximete	
- 1	shock, or heart failure. List IMMEDIATE CAUSE (Fine)	only one cause on eac	n line.	,				Interval Between Onset and Death	
	disease or condition a. Fallopeon Tube Cance							4 mm	
	DUE TO/OR AS A CONSEQUENCE OF):								
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2	CAUSE (Disease or Injury	Dura	ry	un	No	Rige		years	
Ē	that initiated events resulting in death) LAST PART DUE TO [OR AS A CONSEQUENCE OF]								
CERTIFICATION	Cerebral Vascular Jacan								
AL	PART ii. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS								
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ME	1 T YES 2 NO								
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN								
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	PLACE OF DEATH				-		
YSI	1 ☐ YES 2 MO 16	Inpatient 2 ER/Outpati		OTHER:	e 5 🗆 Reeldence	6 Other (Specify)			
F	27. MANNER OF DEATH Natural 5 Pending	(Month, Day, Year)	26b. TIME (WO WO	URY AT RK?	28d. DESCRIBE HOW INJURY	OCCURED		
B	2 Accident Investigation				ES 2 NO				
<u>E</u>	3 Suicide 6 Could not be determined 25e. PLACE OF INJURY — At hom building, etc. (Specify)			ne, farm, atreet, factory, office		28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
	29e. CERTIFIER								
COMPLETED	(Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) and menner es stated.								
8	One) 2 MEDICAL EXAMINE Deele of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) and menner ee stated.								
BE	29c. LICENSE NUMBER 29d. DATE SHOWED (Month/ Day, Year)							(Month/ Day, Year)	
2	20 NAME AND ADDRESS OF RESON HILLS CONTROL OF THE STATE O								
	30. NAME AND ADDRESS OF PENSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) 17/100, Print) THH, BALT M.N.								
ŀ	31. DATE FILED (Month, Day, Yell) / 324 REGISTRAR'S GRATURE								
	FEB 1 5 1895 July d'Audion Recharge								



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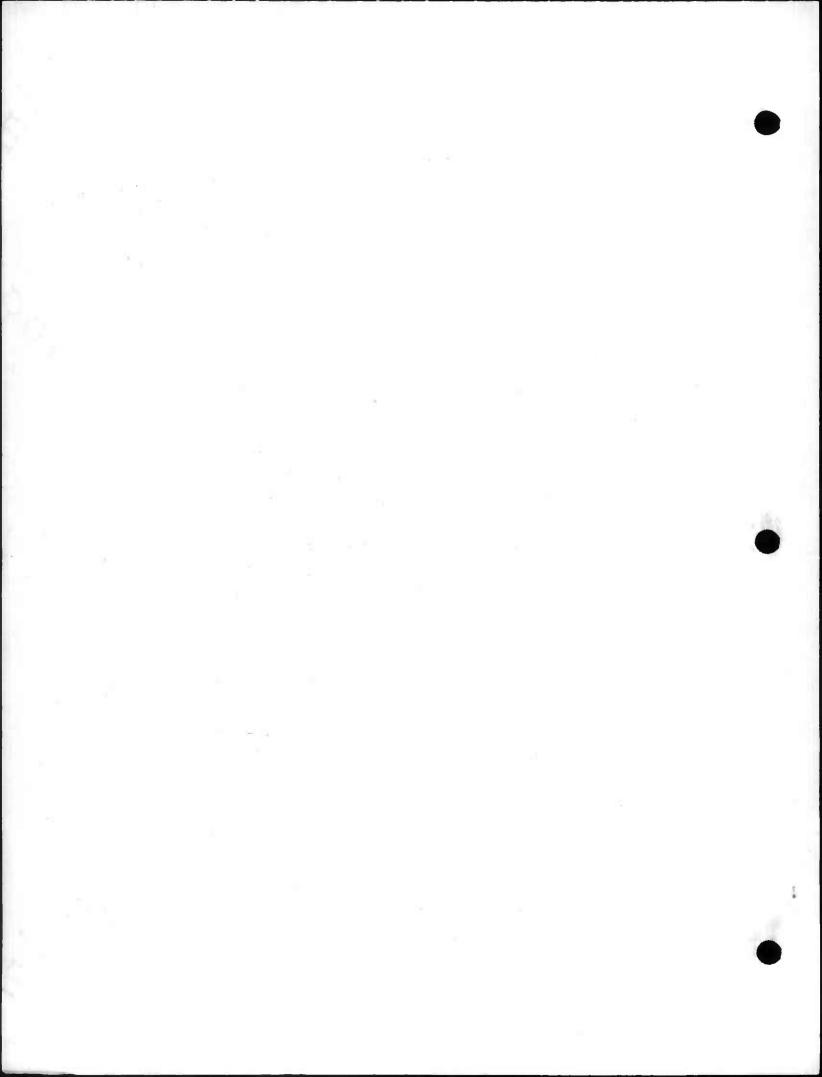
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TO THE HOSPITAL OF ATTENDANT THE law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL INTEGERAL TO A CHARGE AS DEEN SIGNED BY the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours with the first Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFICA	TE OF	DEATH	REG. NO	D.	
- N	1. DECEDENT'S NAME (First, Middle, Last)	-				2. DATE OF DEATH		3. TIME OF DEATN
	Jerome	KALL	.0				13, 1995	10:05 0 H
		SEX 6. AGE (In yrs.		IDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		NPLACE (State or Foreign
	217-03-7116 1	ØM2□F 82	4404		HOURS MIN.	Month, Day, Your) MARCH 22,	Coun	Teur Your
1	9a. FACILITY NAME (If not institution, give street			HTY, TOWN	OR LOCATION OF DE		9c. COUNTY OF	DEATH
DIRECTOR	MCKI GIAN /	FRANKLIN W.	0005				BA.	Homere
EC	10a. STATE 10b. COUNTY	,	10c. CITY, TOV	N OR LOCA	TON			10d. INSIDE CITY
	MARYLAND /	TARFORD			BULA	TR		1 YES 2 NO
FUNERAL	300 SUNFLOE	ver Drive	Apt 2	04 10	ZIP CODE	4		S-A.
5		. WAS DECEDENT EVER IN U.S.	ARMED	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Y	ee or No- 14. RAC	E — American Indian,
ВУ Б	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	ano		2 An Specify	n, Puerto Rican, etc.)	Spec	ck, White, etc.
	15. DECEDENT'S EDUCATI		DECEDENT'S USUA	L OCCUPATION	ON	16b. KIND OF B	USINESS/INDUSTRY	
E	(Specify only highest grade continued (Specify only highest grade continued (Specify only highest grade continued (Specify only highest grade continued (Specify only highest grade continued (Specify only highest grade continued (Specify only highest grade continued (Specify only highest grade continued (Specify only highest grade continued (Specify only highest grade continued (Specify only highest grade continued (Specify only highest grade continued (Specify only highest grade continued (Specify only highest grade continued (Specify only highest grade continued (Specify only highest grade continued (Specify only highest grade continued (Specify only highest grade (Specify only highest grade continued (Specify only highest grade (Specify only high		(Give kind of work de life. Do NOT use retin	one during mo id.)	st of working	D	DONIA	1/
COMPLETED	12+7			tR5	er	1 ~	CONIA	VILLAge
Ö	17. FATHER'S NAME (First, Middle, Last)	2	-		18. MOTNER'S NA	ME (First, Middle, Maide	n Sumeme)	
BE	& locchino	KALLO			MA	Ry GL	LARRE	CRA.
2	190. INFORMANT'S NAME (Type/Print)	ALLO				Route Number, City or To		BURIR
		PLLO	300	Sun	FLOWER	2 DR HAD	+ 204	Md 21014
	20e. METNOD OF DISPOSITION 1 Suriel 2 Cremetion 3 Removal 4 Donation 5 Other (Specify)	from State cemetery.	CEAND DATE OF DIS Crematory or other pic	ice) 4	emeter		BALTO	own, State Manufacts
- 1	21. SIGNATURE OF SUNEBAL SERVICE LICENS	ey s	1			CILITY		inverse.
	· Noall	Zaun	in			IKLING 5		Med Home
	23. PART 1. Enter the diseases/or com	ofications that ceused the	deeth. Do not er	ter the mo	de of dying, suci	h as cardiec or ree	piratory erreat,	Approximate
	ehock, or haert failure. List IMMEDIATE CAUSE (Finel	dniy one cause on sech ii	ne.					Intarval Between Onset end Death
	disease or condition resulting in death)	Ischemic	emic Cardiomyopathy				voars	
	a	DUE TO (OR AS A CONS			1			many
z	b.	Coronary 1	Artery	Dise	ase			veais
CERTIFICATION	Sequentially list conditione, if any, leading to immediate	DUE TO (OR AS A CONS	SEOUENCE OF):					
2	CAUSE (Disease or Injury	DUE TO COD AS A CONT	EQUEURE OF					
Ë	that initiated events resulting in death) LAST	DUE TO (OR AS A CONS	SECUENCE OF):					
8	d							
I	PART II. Other significant conditions of					Part I. 24s. WAS A		b. WERE AUTOPSY FINDINGS
8	Chronic Obstr	ructure Puli	monary	DIS	ease	1 _ YES	PRMED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE
ME	Paralyzed Le	Ct Diaphra	29m					OF DEATH?
44			0			_		
ΧI	25. WAS CASE REFERRED TO MEDICAL			26. Pt	ACE OF DEATH (Che	eck only one)		
PHYSICIAN		OSPITAL: Inputient 2 ER/Outpatient		IER: Nursing Hom	e 5 🗆 Residence	8 Other (Specify)		
Ä	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJ	URY AT	28d. DESCRIBE NOW	INJURY OCCURED	
BY	1 Natural 5 Pending 2 Accident Investigation	(MONIII, Day, 16ar)	INJUNY	1 🗆	RK? res 2 \(\) NO			_
	3 Suicide S Could not be	28e. PLACE OF INJURY — At building, atc. (Specify)	home, farm, atreet,	fectory, offic		28f. LOCATION (Street City or Town, State		Route Number,
COMPLETED	4 Nomicide determined					Ony or lown, State	9)	
7	290. CERTIFIER 1 CERTIFYING PHYSICIAN	N: To the best of my knowledge,	death occurred at t	he time, date	end plece, end due	to the ceuse(e) end m	enner ee stated.	
8		On the basie of examination end/o						e) end menner ee stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM	ABER	29d. DATE SIGNED	O (Month, Day, Year)
9E	Carol Kiche	andson mI	>		D463		> Febru	any 14,1995
ဥ	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH (I'	TEM 27) (Type, Print)				BWIT	more
	CAROL RICHAM	2DSON MD,	9000 Fr	LANIC	LIN SQUI	ARE DRIV	E MD	21237
	FEB 1 5 1995	DELICATION REPORTS						



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Îte	em # 13 a Film # G 720 2	2-15-95 N.A. P	er Funeral	home			93) U	4336
	1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H			GIENE G. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DE		3	. TIME OF DEATN
1	Seawood Lero	eroy Richardson					v 9, 19	YEAR Q5	M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIR	т́н		ACE (Stata or Foreign
	215-18-9756	1 X M 2 🗆 F	77 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, May 8,			yland
	9a. FACILITY NAME (If not institution, give str	eet and number)		9b. CITY, TOWN C	OR LOCATION OF D			NTY OF DEA	
l e	5808 Race Road Elkridge Howa							Howard	3
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		40- 0/74	TOWN DR LOCAT					
E			1,000						Dd. INSIDE CITY LIMITS?
	Maryland How	vard	E	1kridge	. ZIP CODE				YES 2 NO
FUNERAL	5808 Race Road			100			log. Cit		AL COUNTRY?
N.	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13 WAS DEC	21227 ENDENT OF NISPAI	NIC OBIGIN2 (See	olfy Vee or No	USA	- American Indian,
	1 Never Married 2 😾 Married	FORCES? 1 TYES	2 NO	If yes, sp	ecity Cuban, Maxica 2 ND Specif	an, Puerto Rican, e	HC.)	Black, V	White, etc.
ВУ	3 Widowed 4 Divorced	ii izo, dire inii on e	ALCO	I TES	Z [] NU Specii	γ:		Specify:	Bl.l.ack
COMPLETED	15. DECEDENT'S EDUC	ATION completed)	16a. DECEDENT'S U	ISUAL OCCUPATION done during mo	ON et of working	16b. KIND	OF BUSINESS/INC	DUSTRY	D1.1.ack
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)	at or working				
MP	Grade School		Self E	mployed			Florist		
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S NA	ME (First, Middle,	Maiden Surname)		
BE	Moses Richardson				Lucy C	rowner			
2	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural			,	
-	Dorothy T. Richas				d Elk				
	20a, METNOD OF DISPOSITION 1 X Burial 2 Cremation 3 Ramo	val from State 201	D. PLACE AND DATE OF metery, crematory or oth	DISPOSITION (Na er place)	rna of	Feb 2	ec. LOCATION —		
	4 Donation 8 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	M	netery, crematory or oth D Veteran	Cemeter	ry/Garri	son I4	Owings	Mill	s, Marylar
		8 \ L		2501	Gwvnns F	alls Pa	erFuner: rkwav	al. Hor	mes, Inc
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY NUTTER Funeral. Hom 2501 Gwynns Falls Parkway Baltimore, Maryland 21216									
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory errest, abook, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (DR AS A CONSEQUENCE OF):								
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (DR AS A CONSEDUENCE OF): c. DUE TO (DR AS A CONSEDUENCE OF):								
핑	DART II Other significant conditions	and the standard at the							
g	PART II. Other algnificant conditions	contributing to death t	out not reaulting in	tha underlying	g cause given in		ERFORMED?	A	ERE AUTOPSY FINDINGS WAILABLE PRIOR TO
PHYSICIAN: MEDICAL						10	YES 2 NO		OMPLETION OF CAUSE F DEATH?
Σ	DID TODACCO LIST COLUMN	IDLITE TO CALICE O	E DEATH VE		1			1	YES 2 ND
AN	DID TOBACCO USE CONTR	IBUTE TO CAUSE C	26. PLACE DF DEATH		UNCERTAI	и 🗀 📗			
ਲੋ	EXAMINER?	HOSPITAL:		OTHER:					
¥	27. MANNER OF DEATN	1 Inpatient 2 ER/Out	28b, TIME		e 5 Residence		NDW INJURY OC	OURED	
	1 Natural 5 Pending	(Month, Day, Year)	INJU		RK?	200. DESCRIBE	NOW INJURY OC	COHED	
B	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY	— At home, farm, str			28f LOCATION	Street and Number	or Rumi Bou	to Mumber
COMPLETED	4 Nomicide 6 Could not be	building, atc. (Spe	cily)			City or Town		or narez noor	in ivamon,
Ш	29a. CERTIFIER CERTIFYING PAYOR	IAN: To the best of my know		Laster as		5754			
N N		On the basis of examination							od manner as stated
	29b. SIGNATURE AND TITLE OF CERTIFIER							200	
BE	Much las 11	da la box			N ZQ ZO				Ionth, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WND	COMPLETED CAUSE OF DE	ATN (ITEM 27) (Type 4	Print)	D3850	7	Tel.	KUMLA	10 1995
	11065 Little Patiex	eny Phon		mel	21044				
	31. DATE FILED (Month, Day, Year)	22, REGISTRAR'S SIGN	ATURE		- /			_	
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		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART				GIENE a. no.	
		1. DECEDENT'S NAME (First, Middle, Last)	nn .	SANK			2. DATE OF DE		3. TIME OF DEATH S 0805A M
Pir		220-20-9251	1 🗆 M 2 🗡 F		IF UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIRT	(H) 1929 (BIRTNPLACE (State or Foreign Cauntry)
. 2, 3 should	TOR	99. FACILITY NAME (If not institution, give street of the control	BOHa	9	Balti	OR LOCATION OF DE	EATN	9c. COUNTY	OF DEATH
permit. Pages 1,	DIRECTOR	100. STATE 10b. COUNTY			TOWN OR LOCAT				10d. INSIDE CITY LIMITS? 1 X YES 2 NO
isi	FUNERAL	100. STREET AND NUMBER 2502 Bangers	treet			1. ZIP CODE 2123	D	100. CITIZE	N OF WHAT COUNTRY?
215-0020 attending physician. se as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, spe	ENDENT OF NISPAN ecity Guben, Mexica 2 NO Specify	in, Puerto Rican, e	Ify Yee or No-	. RACE — American Indian, Black, White, etc. Specify:
F 5 2	ETED	15. DECEDENT'S EDUCA (Specify only highest grade co		18e. DECEDENT'S US (Give kind of wor life. Do NOT use i	rk done during mos	ON all of working		OF BUSINESS/INDUS	^
	COMPL	17. FATHER'S NAME (First, Middle, Last)	Conege (1-0 or 0 +)	Teleph	none C	Perator			Company
YLA by the be del	BE CO	William O. Kr	ennedy			Saral	ME (Figs), Middle, A	feiden Surname)	
	TO	Sarah Mercer		218	Marq	and Number or Rural I		Oriown, State, ZID Co	ND 21060
ORE 6 may ector, pa		2 METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Remove a Donation 5 Other (Specify)		D. PLACE AND DATE OF Interest, crematory or bite				DO 138	or Townstate
ALTIMOR death. Page 6 mile functor, i.		21. SIGNATURE OF FUNERAL SERVICE LICEN				ND ADDRESS OF FA	meral !	tome Fr	
BAI in by the fur removal.		23. PART I. Enter the diseases, or cor	molications that cause	d the death. Do not	113287	SUMPHUES	Sprindk	oad Balt	more MD 21827
or n		IMMEDIATE CAUSE (Finel	et only one ceuse on e	ech ilne.		ue or uying, eas	II as colores	reapiratory enses	Approximata Interval Between Onset end Deeth
d within e. ompletely file 1, cremation, event, the		resulting in death) e.	SEDSES DUE TO (OR AS A				^		6 days
OX 687(e) be executed sician and coming to burial, traumatic events.	rion	Sequentially list conditions, if any, leading to immediate		A CONSEQUENCE OF):	allue_	with	ocidos	23	2 veels
B. phy	RTIFICATION	cause. Enter UNDERLYING CAUSE (Diseese or Injury thet initiated events	DUE TO (OR AS A	consequence of:					> fyeors
teath cert attending mal Hygie	CERTI	resulting in death) LAST	hyperleuse	ou					10 glan
DRDS, F that the death d by the atte and Memal my injury, o	AL	PART II. Other algnificent conditions	contributing to deeth b	ut not resulting in	the underlying	ceuse given in	Pi	AS AN AUTOPSY ERFORMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE
MECOR Meduires that sheen signed by pt. of Health an Shows any	MEDIC						_	ES 2 HO	OF DEATH?
S b b c b c b c c c c c c c c c c c c c	SICIAN:	DID TOBACCO USE CONTRIL 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH		UNCERTAIN	V 🔲		
. 5 5 5	IYSIC		HOSPITAL:	petient 3 DOA 4		e 5 🗆 Residence			
ON OF DING PHYSIC After this ce death with the marked,	ву РНҮ	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIME C	M 1 Y	RK? rES 2 NO	26d. DEŞCRIBE I	NOW INJURY OCCUR	ED
TTENDI TT		3 Suicide e Could not be determined	26e. PLACE OF INJURY building, atc. (Spec	— At home, farm, stre	et, factory, office		28f. LOCATION (S City or Town,	Street and Number or State)	Rural Route Number,
로 국 가 모 =	COMPLETED		AN: To the best of my knowl						
TO THE HOSPITAL. TO THE FUNERAL be filed within 72 IMPORTANT: If		296. BIGNATURE AND TITLE OF CERTIFIER	On the pasts of examination	n end/or investigation,	In my opinion, de	eath occured at the 29c. LICENSE NUM			gned (Month, Day, Year)
E SE SE	TO BE	30. NAME AND ADDRESS OF PERSON WHO C	land M	D.		206		▶ 2,	112/95
1)		ROBERT KASZUBA	4 ST. AG	NES HO	SPITAL	900 CA	TON AU	E, BALTI	MOKE, 10, 21229
_ 1		FEB 1 5 1995 July	32 REGISTRAR'S SIGNA	Lall,					

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BALTIMORE, MARYLAND 21215-0020	Aprilled within there offer death. Dane & may be referred by the bounded as second as all also
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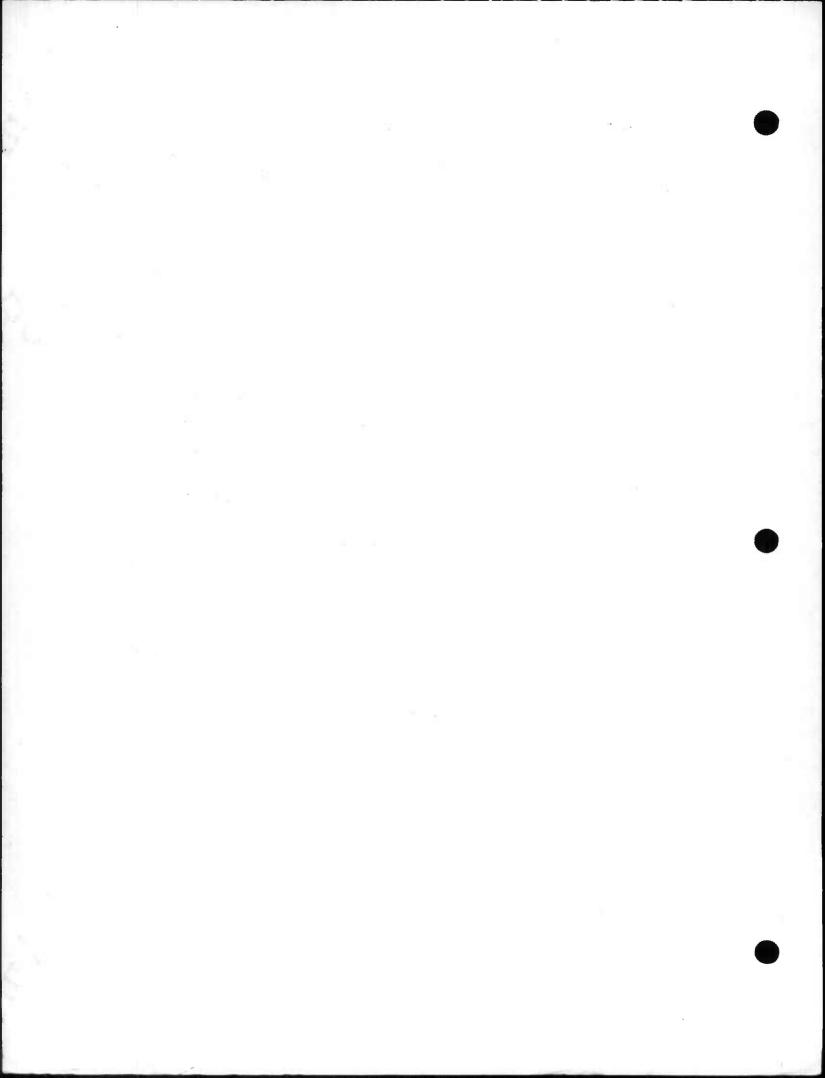
	95 04558
	FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
	REGISTRAR CERTIFICATE OF DEATH REG. NO.
1	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH
- 6	STEPHEN C. Savage, Sr. Feb 13 95 19:550 M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthdey) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign
7	216-07-9309 1 M 2 F 88 YRS. MONTHS DAYS HOURS MIN. 5(MONTH) DRY, Year) MONTHS DAYS HOURS MIN. 5(MONTH) DRY, Year) Mary and
_ 1	9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH
OR	St. Agnes Hospital Baltimore
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d INSIDE CITY
E E	Manual Code Co
֖ׅׅ֚֡֝֞֜֜֝֜֜֝֜֜֜֜֜֜֜֜֜֓֓֓֓֓֜֜֜֜֜֜֜֜֓֓֓֓֓֓֜֡֜֜֡	40. STREET AND MULLER
FUNERAL	2027 Tanice Avenue
NE I	United States
Ē	1 Never Merried 2 Merried FORCES? 1 YES 2 DINO If yes, specify Cuben, Mexican, Puerto Rican, etc.)
В	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: Specify:
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working
Щ	(Specify only highest grade completed) [Give kind of work done during most of working life. Do NOT use refired.] [Give kind of working life. Do NOT use refired.]
N N	Wight Watchman Kailroad
COMPLETED	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme)
BE	David Savage Ella
0	19e, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number of Rural Route Number, City or Town, Stete, Zip Code)
	Jean Sprinkle 3027 Janice Avenue, Baltimore, MD 21230
	20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crematory or other-place) 20c. LOCATION — City or Town, State
	4 Donatton 5 Dother (Specify) Gardens of tay the long to the respective of the second
	21. SIGNATURE OF FUNERAL SETTICE LICENSES 22. NAME AND ADDRESS OF FACILITY Ambrose F.H. of Lansdowne
	2719 Hammonds Fry. Rd., Lansdowne, MD 21227
1	23. DART I. Enter the diseasea, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between
1	IMMEDIATE CAUSE (Final Onset and Death
	disease or condition resulting in death) a. ACUTE MYDCARDIAI LNFADCTION DUE TO (OR AS A CONSCOUENCE OF):
- 1	
5	Sequentially list conditions, Due to (OR AS A CONSCOUENCE OF):
HIFICATION	If any, leading to immediate cause. Enter UNDERLYING SENERAL, zed ATHEROSCIEROSCI
5	CAUSE (Disease or injury that initieted events DUE TO (OR AS A CONSEQUENCE OF):
	resulting in death) LAST
2	d.
AL	PART II. Other aignificent conditions contributing to death but not recuiting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY FINDINGS AMAILABLE PRIOR TO
MEDICAL	Severe Typing SEMA; HISTORY OF 1 YES 2 NO COMPLETION OF CAUSE OF DEATH?
Ž.	Lerebra ANEURYSM
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN
PRISICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? DTHER: 25. PLACE OF DEATH (Check only one) OTHER:
2	1 PES 2 PRO 1 Propertient 2 ER/Outpettent 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)
5	28. DATE OF INJURY 1 Of Metural 5 Pending 28. DATE OF INJURY (Month, Day, Year) 28. TIME OF INJURY AT WORK? 28. INJURY AT WORK?
	2 Accident Investigation Types 2 No
3	3 Suicide 8 Could not be determined 4 Homicide 8 Could not be determined 4. Specify) 28e. PLACE OF INJURY — At home, term, atreet, fectory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
	1 CERTIFIER (Check only one) one)
5	2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
u l	29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year)
5	Attending Physician D16200 > 2/13/95
	IS. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Frint)
	DR N Machivan 720 Maiden Choice LA, Catonsville 21228
1	11. DATE FINED (Month, Day, Year) a 328 REGISTRAR'S ACNATURE

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IYSICIAN. The law requires that the death certificate be executed within a mours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		notified at once.
nice nours after death. Page 6 may 1	tely filled in by the funeral director, pag	nation, or removal.	t, the medical examiner must be
hat the death certificate be executed with	1 by the attending physician and complet	the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	d, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ING PHYSICIAN: The law requires th	After this certificate has been signed	leath with the State Dept. of Health	is marked, or item 23 shows an
TO THE HOSPITAL OR ALTEND	THE PUNETAL DIRECTOR: 1	be filed within 72 hours after 6	INPORTANT II Item 28 is

	FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTMENT OF		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
	Sweetie	SI	helton		2 - 13	8 - 95	9:30 A M
	4. SOCIAL SECURITY NUMBER 5.	SEX 8. AGE (In yrs. I			7. DATE OF BIRTH	8. 1	SIRTHPLACE (State or Foreign
	2/5 30 0 994 1 9e. FACILITY NAME (If not institution, give street	□ M 2 Ø F 97	YRS. MONTHS DAY		(Month, Day, Year)	3	VA.
5	Md. Tenera	L HOSP	96. CITY, TOW	NOR LOCATION OF DI	EATH	9c. COUNTY	OF DEATH
ا ڌِ	RESIDENCE OF DECEDENT		1				
DIMECTOR	10a. STATE 10b. COUNTY		Balto				10d. INSIDE CITY LIMITS? 1 YES 2 NO
4	10e. STREET AND NUMBER	ti au		10f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	633 A159611	1 ST		21207	2	4.5	1
5		PORCES? 1 YES 24			NIC ORIGIN? (Specify Ye	e or No- 14.	RACE — American Indian, Black, White, etc.
2	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES		specify Cuben, Mexice ES 2 NO Specif	y:		Specify: 2 1
- 1	15. DECEDENT'S EDUCATI	1011					DRANK
4	(Specify only highest grade con	npleted)	DECEDENT'S USUAL OCCUPA (Give kind of work done during ife. Do NOT use retired.)	most of working	16b. KIND OF BU	SINESS/INDUST	RY
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	BALY	5, Her			
5	17. FATHER'S NAME (First, Middle, Last)		0,,,,,	18. MOTHER'S NA	ME (First, Middle, Meiden	Sumamal	
		OBINSON		9001	>	AC - 4	/
2	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street			n. State. Zip Coc	/ del
2	ALTHIA ROL		133 A15911	TIST A	T7 F 84	DIE 4	11 21202
1	200. METHOD OF DISPOSITION	20b. PLAC	EAND DATE OF DISPOSITION	(Name of	OATE 20c. LC	CATION — City	or Town, State
	1 Buriel 2 Cremetion 3 Removal		rematory or other plede)	In 2m PK	177 723	TO Wa	oh, Blod-
	21. SIGNATURE OF FUNERAL SERVICE LICENS			AND ADDRESS OF FA	CILITY		1
	Joseph 15, 2	tooks fr	Loz	ks 7 mm	el Harl	130	4). Central Rp
	23. PART i. Enter the diseases, or com	plicetions thet ceused the	deeth. Do not enter the	node of dying, suc	h es cerdiec or reap	iratory errest,	
	iMMEDIATE CAUSE (Fine)	t only one cause on each lin	ne.	-	longogtiv	to II an	Interval Between Onset and Death
ı	diseese or condition resulting in death)	Cerebrovas	scular Acc	ident [Congestiv Cailure	те неа	unknown
		DUE TO (OR AS A CONS	EOUENCE OF):	, ,	arrure		
5	Sequentielly list conditions, b.	AtrialFibl		Myocard	lial Infa	rctio	n.
HILLAIION	if eny, leading to immediata	OUE TO (OR AS A CONS	EOUENCE OF):				
2	cause. Enter UNDERLYING CAUSE (Disease or injury	BUE TO COD AS A DOUG					
	thet initieted events resulting in deeth) LAST	DUE TO (OR AS A CONS	EOUENCE OF):				i l
	d						
4	PART ii. Other aignificant conditions of	ontributing to death but not	reaulting in the underly	ing ceuse given in	Part i. 24a. WAS AN		24b. WERE AUTOPSY FINOINGS
					PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE
						X.	OF DEATH?
	DID TOBACCO USE CO	INTRIBUTE TO CAL	JSE OF DEATH	YES NO			
PHTSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	QSPITAL:		PLACE OF DEATH (Ch	eck only one)		
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Inpatient 2 ER/Outpatient	3 DOA 4 Nursing H	ome 5 - Residence	6 Other (Specify)		
5	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF 28c.	INJURY AT WORK?	28d. DEŞCRIBE HOW	INJURY OCCUR	ED
5	1 KNetural 5 Pending 2 Accident Investigation			YES 2 NO			
3	3 Suicide 6 Could not be 4 Homicide detarmined	26e. PLACE OF INJURY — At I building, etc. (Specify)	home, ferm, street, fectory, o	ffice	281. LOCATION (Street City or Town, State	and Number or F	Rural Route Number,
- 1							
u n		N: To the beet of my knowledge,					
				, death occured at the	time, date end place, er	nd due to the ce	use(a) and manner as stated
È	(Check only TX CERTIFTING PHYSICIAL	On the basis of examination end/o	r investigation, in my opinior				design and mainter se stated.
È	(Check only 2 MEOICAL EXAMINER: C			29c. LICENSE NUI			GNEO (Month, Day, Year)
È	(Check only 2 MEDICAL EXAMINER: (29b. SIGNATURE AND TITLE OF CERTIFIER	Hous	E STAFF	20c. LICENSE NUI	WBER	29d. DATE SIG	
È	(Check only 2 MEDICAL EXAMINER: (29b. SIGNATURE AND TITLE OF CERTIFIER	Hous	E STAFF	20c. LICENSE NUI	WBER	29d. DATE SIG	GNEO (Month, Day, Year)
M BE COMPLE	(Check only 2 MEOICAL EXAMINER: C	Hous	E STAFF	20c. LICENSE NUI	WBER	29d. DATE SIG	GNEO (Month, Day, Year)



BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH SEWELL MARGARET 3 10.30P 1991 02 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign HOURS DAYS. 1 M 2 F 220-22-3891 YRS 88 24. April 1900 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Northwest Hospital Center Baltimore Randallstown 10h COUNTY 10a STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1 YES 2 NO FUNERAL 100. STREET AND NUMBER
LOCHEARN 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 3715 Lecher Drive 21207 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No-if yes, specify Cuban, Maxican, Puerto Rican, atc.) 1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, alc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY Specify 3 X Widowed 4 Divorced Bl.ack COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b, KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 7th Grade Homemaker/Domestic Private Families 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Surname) George Parker Lucinda Johnson BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5 3715 Lochearn Drive Margaret B. Wells Baltimore, Maryland 21207 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION /Name of DATE 20c. LOCATION -- City or Town, Slata 1 N Burial 2 Cremation 3 L 4 Donation 5 Other (Specify) Buriel 2 Cremetion 3 Removal from Stale Feb₁₈ Harmons, Maryland Saints Rest Cemetery 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, 2501 Gwynns Falls Parkway F FUNERAL SERVICE LICEN Inc Naltimore, Maryland 21216 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or reepiratory errest, shock, or haert feiture. List only one ceuee on each line. Approximate intarval Batween PNEUMONIA **IMMEDIATE CAUSE (Final** Onset end Death disease or condition des recuiting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly liet conditiona, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 THO OF DEATH? 1 YES 2 -40 PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO Milent 2 - ER/Outpatient 3 - DOA ng Home 5 Rasidenca 8 Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF-DEATH 28b. TIME OF INJURY 28c, INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation м 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, streel, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 8 Could not be 4 Homicide 1 CERTIFYING PHYSICIAN: To the beal of my knowledge, death occurred at the lime, date and pieca, and due to the cause(a) end menner as stated. (Check only one) 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the IIma, data and place, and due to the cause(a) and manner as stated. HE SIGNATURE AND TITLE OF CENTIFIES 29d. DATE SIGNED (Month. Day. 29c. LICENSE NUMBER H 404 10 2 SS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 0 MA RIA2 NWH 31. ONTELFILED MONTE 32. HEGISTRANSATIONALINE

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

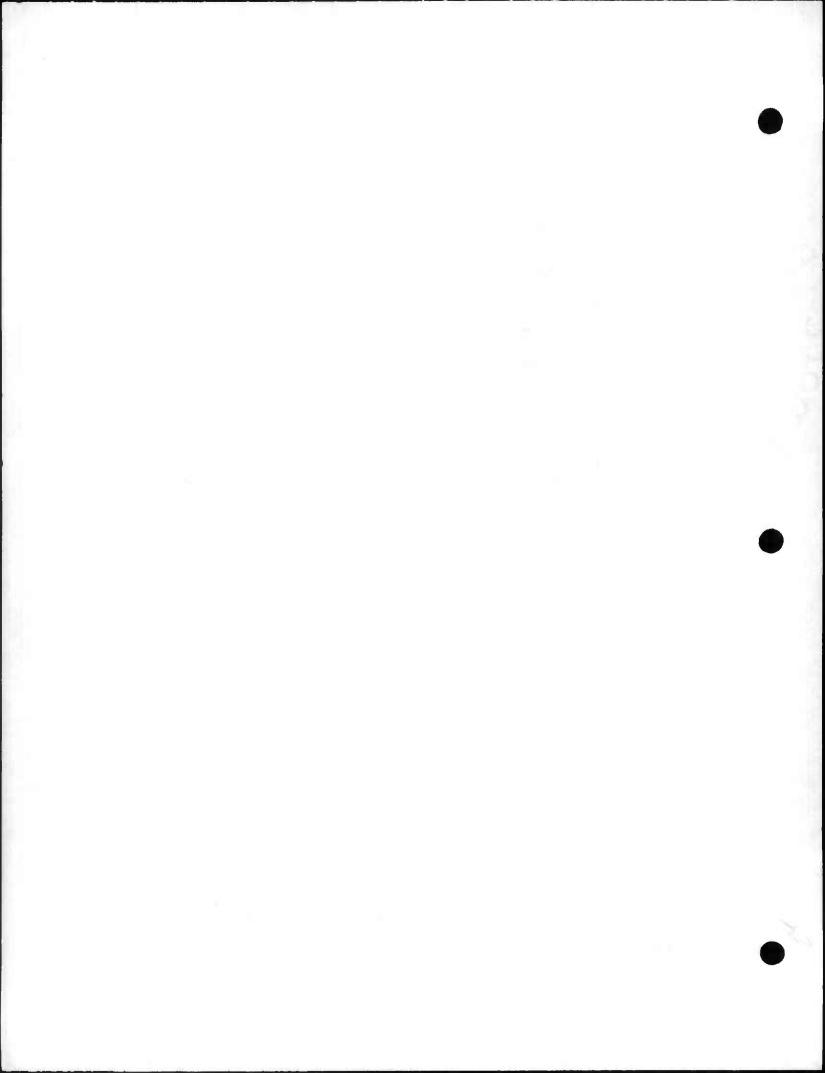
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	TILOIOTTONI		-		CAIL	JE DEM		REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)	CAROLYN MARY	STREJO	EK	V_	•	2	DATE OF DEATH	ر (۳	YEAR 1 TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX 8. /	GE (In yrs. la.	st birthday)	IF UNDER t YE	AR IF UNDE	R 24 HRS. 7	DATE OF BIRTIN	-	8. BIRTHPLACE (State or oreign
	213-01-9706	1 □ M 2 🂢 F 🕳	901	91 YRS.	MONTHS DA		MIN. S	(Manth Plant Mant)	1903	Maryland
	9e. FACILITY NAME (If not institution, give st	treet end number)			96. CITY, TO	WN OR LOCAT				ITY OF DEATH
5	Mercy Medical Center					imore			N/A	
DIRECTOR	RESIDENCE OF DECEDENT								1.771	
뿐	10e. STATE 10b. COUNTY				town or b					10d. INSIDE CITY LIMITS?
						Le				1 TYES 2 NO
FUNERAL	100. STREET AND NUMBER 8067 Woodhaven R	oad				101. ZIP COC			_	ZEN OF WHAT COUNTRY?
3	11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. AF	RMED	13. WAS	OECENDENT	OF HISPANIC	ORIGIN? (Specify Yes		14. RACE — American Indian,
≽ B	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		NO	If yes	yes 2 NO	en, Mexicen, F	Puerto Ricen, etc.)		Black, White, etc. Specify: White
	15. DECEDENT'S EDUC (Specify only highest grade	CATION Completed	16a. Ot	ECEDENT'S U	ISUAL OCCU	PATION		16b, KIND OF BUS	SINESS/IND	USTRY
91	Elementary/Secondary (0-12)	College (1-4 or 5+)	1			g most of worki	ing			
		N/A	H	omemal	rer			Own Hon	ne	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)							(First, Middle, Meiden	Surname)	
BE	Joseph Fajman						na Tes			
2	19a. INFORMANT'S NAME (Type/Print)	1 10 1	19	b. MAILING /	ADDRESS (St	set and Numbe	or or Rural Rout	te Number, City or Town	n, State, Zip	
-	Joyce Hay Kabak		tr)	8067 V	Voodho	wen Ro	oad, B	saltimore,	Md.	21237
	20e METNOD OF DISPOSITION 1.X Burlel 2 Cremation 3 Remo 4 Ocception 5 Other (Specify)	oval from State	206. PLACE	AND DATE OF	PISPOSITION RELEGIO	niname of mer Co	2m. 2	0ATE 20c. LO		city or Town, State Ore, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE						Tal Home	-	o co, made agreement
	Tabertina	MIN			333	11 Brel	rms La	ne, Balti		
- 1	23. PART i. Enter the diseases, or c shock, or heart fellure. I	omplications that cal	used tha de	eath. Do no	ot antar tha	moda of dy	ring, auch a	a cardiac or raspi	ratory arre	
	IMMEDIATE CAUSE (Final						•			intarvai Batween Onset and Death
J	disease or condition resulting in death)	516	OKE	=2	ML	ILTIK	OLE	. WITE	1	DNF WE
		DUE TO (OR	AS A CONSE	QUENCE OF	0.4.		/			
2	Sequentially list conditions,	disease or condition resulting in death) a. STROKES MULTIPLE, WITH ONE WEEK Sequentially list conditions. b. SILATERAL AEMVPLEGIA								
Ĭ	if any, leading to immediate cause. Enter UNDERLYING	OUE TO (OR	AS A CONSE	QUENCE OF)				•		
RTIFICATION	CAUSE (Disease or injury	OUE TO (OR	AS A CONSE	OUENCE OF						
	that initiated events resulting in death) LAST	00E 10 (0K	AS A CONSE	OUENCE OF).						
		1								
- 11	PART II. Other aignificant conditions	a contributing to daa	th but not i	reaulting In	tha under	ying cause	given in Par	rt i. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDICAL	CONGEST	NE HE	AK	1 7	1114	NKE	^	1 TES 2		COMPLETION OF CAUSE OF DEATH?
ME	ATRIA	1 +45	RIL	LASU	ON		/		^	1 TYES 2 NO
	DID TOBACCO USE CONTR				□ NO	□ UNC	CERTAIN			
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLAC	CE OF DEATH		one)				
	1 YES 2 NO	HOSPITAL: 1 ☐ Inpetient 2 ☐ ER/	Outpatient 3		OTHER:	Nome 5 🗆 R	eeldence 6	Other (Specify)		
HÀ	27. MANNER OF DEATH	28e. OATE OF INJU (Month, Day, Ye		28b. TIME INJU		INJURY AT WORK?	28	d. OESCRIBE HOW II	JURY OCC	URED
- 1	1 Naturel 5 Pending Investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				YES 2	NO			
2	3 Suicide 8 Could not be	28e. PLACE OF INJ building, etc.	URY — At he	ome, 1erm, str	reel, lectory,	office	28		nd Number	or Rural Route Number,
COMPLEIED	4 Homicide determined							City or Town, State)		
ž 1	29e. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my k	nowledge, de	eath occurred	at the time.	date end place	end due to t	the cause(s) and men	ner ee state	ad .
E										e ceuse(e) end <i>m</i> enner se stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER			_		-	ENSE NUMBE		29d, DATE	
ă	/Wan C	Yhu	mx			7) -	-/19	280	DATE	2/10/95
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	DEATH (ITE	M 27) (Type, F	Print)	10	0/0	200	0	21001
	NEZSON (.	Dun.	wi	30	157	PA	111 8	2405	AM	Tomoper Mis
	31. DATE FILED (Month, Day, Year)	32. REGISTRAD'S	IGNATURE		<i>V</i> /	- / /۷	~~ /	7100	J/10	212
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FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE O	DEATH	REG. NO		
	1. DECEDENT'S NAME (First, Middle, Lest) Anna L. Sikors	ky				2. DATE OF DEATH HONTH DEFENDENCY	~13, 193	3. TIME OF DEATH 95 5:35 p. M
	4. SOCIAL SECURITY NUMBER 218-40-9417	1 - M 2 X F 8	(In yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) NOV. 7. 1	8. Bi	IRTHPLACE (State or Foreign ountry) aryland
OR	Manor Care Ruxto	9a. FACILITY NAME (If not institution, give street and number) Manor Care Ruxton				EATH	BC. COUNTY OF DEATH Baltimore	
5	PESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY							anti-te
DIRECTOR								
IERAL	2911 C. Andor Court 11. MARITAL STATUS 1 Never Married 2 Married 3 M Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO If yes, apecity Cuban, Maxican, Puarto Rican, etc.) 14. RAC Blac Specify Was on Specify: 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, apecity Cuban, Maxican, Puarto Rican, etc.) 16. Specify: 17. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, apecity Cuban, Maxican, Puarto Rican, etc.) 18. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, apecity Cuban, Maxican, Puarto Rican, etc.)							OF WHAT COUNTRY?
BY FUN								ACE — American Indian, Slack, White, etc. Specify: White
COMPLETED								
MPLE	Elementary/Secondary (0-12)	College (1-4 or 5+) N/A		Typist		Secre	tarial	Position
BE CO	17. FATHER'S NAME (First, Middle, Last) John Peters					ME (First, Middle, Meiden Cermak	Sumama)	
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural I	Route Number, City or Tow	n, State, Zip Code,)
10	Charles Sikorsky		2833	Cub Hil	Road,	Baltimore,	Md. 2	1234
1	20e, METHOD OF DISPOSITION 1 A Burlel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	M	DESCRIPTION DATE	"Redeem	er Cem.	2/17/95 B	cation — city o altimor	e, Maryland
	21. BIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SCHUMUNER FUNERAL HOME							Md. 21213
		a. GCafe	ach iina.	not anter tha m	ode of dying, auc	h sa cardiac or reapi	ratory arreat,	Approximate interval Between Onset and Death
ATION	Sequentially list conditiona, if any, laading to immediata cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF	F):				
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	OUE TO (OR AS A	CONSEQUENCE OF	F):				
	DART II Other elections and disc.							
EDICAL	PART II. Other significant condition	os teo a		in tha undariyi	ng causa given in	Part I. 24a. WAS AN PERFOR 1 TYES 2	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
M								1 TYES 2 NO
Z	DID TOBACCO USE CONTE	RIBUTE TO CAUSE O	F DEATH YE	S NO [UNCERTAIN	1 🗆		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEAT)			
YSI	1 TYES 2 NO	1 Inpatient 2 ER/Outp	etient 3 🗆 DOA	OTHER: 4 X Nursing Ho	me 5 🗆 Residenca	6 Other (Specify)		
ву Рн	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	26b. TIM INJ	URY W	JURY AT ORK? YES 2 NO	28d. DESCRIBE HOW II	NJURY OCCURED	
	3 Suicide 8 Could not be 4 Homicide determined	26s. PLACE OF INJURY building, etc. (Spec	— At home, farm, soify)	street, factory, offi	ce	281. LOCATION (Street a City or Town, State)	and Number or Run	ral Route Number,
COMPLETED		CIAN: To the best of my know R: On the basis of examination						se(s) and manner as stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUN	BER	29d. DATE SIGN	IED (Month, Day, Year)
A	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALISE OF OF	ATH (ITEM 97) /3	Print)	10370		- 21	. / 1 / 1
1)	Dr. Kenneth Green	e, 7801 York	Road, S	uite 10	1, Balti	ice vale Bi imore, Md.	ulding 21204	
	31. DATE FILED (Month, Dey, Year)	32 PEGISTRAR'S SON	ATURE					
	FEB 1 5 1995 A	~	11.1					



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O. B(law requires that the death certificate be executed with
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N OF VITAL RECORDS, P.O. BOX 68760	OSPITAL OR ATTENDING PHYSICIAN: The I
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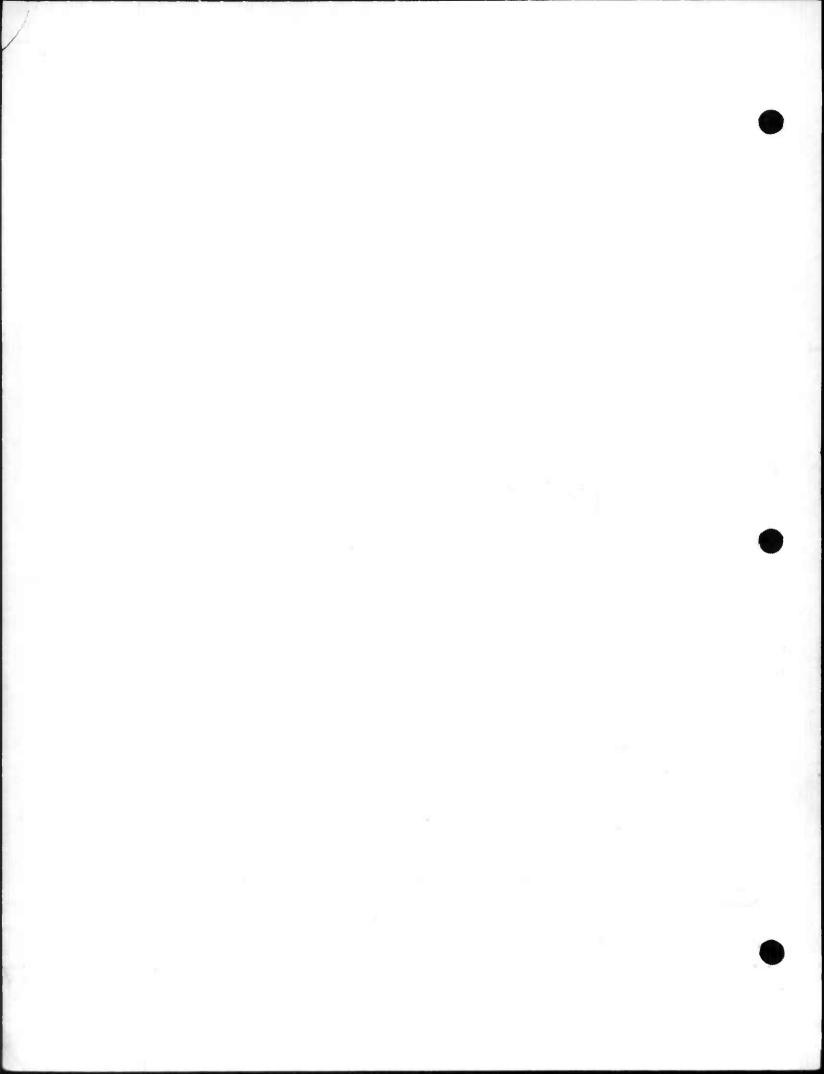
FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY 3. TIME OF DEATH YEAR IVRA SELLERS FEBRUARY 995 10 21:30 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreig 244-36-5948 -63 HOURS North 6-9-29 Carolina 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c, COUNTY OF DEATH DIRECTOR JOHNS HOPKINS HOSPITAL BALTIMORE CITY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Anne Arundel 1 [YES 2 1 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 1234 Crowsnest Court 21403 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. Specify: Black 1 Never Married 2 2 Merried BY 3 Widowed 4 Divorced 18e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Bricklayer Construction 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname)
Flora Huntley Benjamin Sellers BE notified a 19e. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Apyte Number, City, or Town, State, Zip Code), 213 2 Pauline Sellers be 20a METHOD OF DISPOSITION
1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cometery, crematory or other place) laryland Vet. 20c. LOCATION - City or Town, State COWNSVILLE, ND PATE 6 must 4 ☐ Donation 5 ☐ Other (Specify) ... examiner 21. SIGNATURE OF EUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Josh Miller Funeral Home medical 23, PART i. Enter the disessea, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory street, **Approximata** ahock, or heart fellure. List only one causa on each line. interval Between **IMMEDIATE CAUSE (Finel Onest and Death** the disease or condition_ Ventricular 24 hrs traumatic event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Myocardial days CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL shows any 1 YES 2 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: Hem OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Is marked, 1 Natural 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 200 4 Homicide If item 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Sony K. New & M. D.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DZ/10/95 Sonye K. Danoff

32 REGISTRAR'S SONATURE

Johns Hopkins Hospital



	1. DECEDENT'S NAME (First, Middle, Last)	TAC			2. DATE OF DEATH MONTH D	AY A YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER S. S. SEX 718 -12 - 0902 1 1 M 2 1 F	6. AGE (In yrs. lest birt	thday) IF UNDER 1 YEAR WONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Cou	TTHPLACE (State or Foreignetry)
	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN	OR LOCATION OF DE	717-8-19K	9c. COUNTY OF	PEATH DEATH
TOR	CHURCH HOSPITAL		Ва	ltimore	. /		Md.
DIRECTOR	10a. STATE 10b. COUNTY Md .	10	Baltimo		- P		10d. INSIDE CITY LIMITS? 1 YES 2 \(\square\) NO
RAL	10e. STREET AND NUMBER		101	. ZIP CODE			F WHAT COUNTRY?
FUNER	1646 Chilton St. 11. MARITAL STATUS 12. WAS DECEDENT	EVER IN U.S. ARMED	13. WAS DEC	21218	IIC ORIGIN? (Specify Yes		. S . A .
BY	1 Never Married 2 Married FORCES? 1 3 Widowed 4 Divorced FYES, GIVE W	YES 2 NO	If yes, sp	ecity Cuben, Maxica 2 NO Specify	n, Puerto Rican, etc.)	84	eck, White, etc. Black
ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give k	DENT'S USUAL OCCUPATION sind of work done during money NOT use retired.)	ON ast of working	16b. KIND OF BU	SINESS/INDUSTRY	1
COMPL	Elementary/Secondary (0-12) College (1-4 or 5 +		chienist		Conti	nental	Can
Ö	17. FATHER'S NAME (First, Middle, Last)				ME (First, Middle, Maiden	,	
H	James Kenny 19a. INFORMANT'S NAME (Type/Print)	19h M/	AILING ADDRESS (Street a		ie Gross		
2	Renee Washington		646 Chilt				21218
	20a. METHOD OF DISPOSITION 1 General Particles of State Stat	20b. PLACE AND	DATE OF DISPOSITION (No	ame of	DATE 20c. LO	CATION — City or	
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Green	mount Cre	matory ND ADDRESS OF FA		.995 B	alto. Md
	Carlton C. Doc	Jan	Carl	ton C.	Douglass oh St. B		
	disease or condition resulting in desth) a. Condition	OR AS A CONSEQUE	EHEAR NCE OF):	1 66	HUNKE		Mari
ERTIFICATION	cause. Enter UNDERILYING CAUSE (Disease or injury	OR AS A CONSEQUE					
L CERTIFICATIO	If any, leeding to immediate cause. Enter UNDERIX/ING CAUSE (Disesse or injury that initiated events	OR AS A CONSEQUE	NCE OF):	g ceuse given in	PERFO	RMED?	24b. WERE AUTOPSY FINI AMILABLE PRIOR TO COMPLETION OF CA
MEDICAL CERTIFICATIO	if any, leeding to immediate cause. Enter UNDERIX/ING CAUSE (Disesse or injury that initiated events resulting in death) LAST	OR AS A CONSEQUE	NCE OF): ilting in the underlyin		PERFOI	RMED?	24b. WERE AUTOPSY FIND AMILABLE PRIOR TO COMPLETION OF CAL OF DEATH?
AN: MEDICAL CERTIFICATIO	If any, leeding to immediate cause. Enter UNDERIXING CAUSE (Disease or injury that initiated events resulting in desth) LAST PART II. Other significant conditions contributing to DID TOBACCO USE CONTRIBUT 25. WAS CASE REFERRED TO MEDICAL	OR AS A CONSEQUE	NCE OF): Illing in the underlying F OF DEATH 26. PI		PERFOI	RMED?	24b. WERE AUTOPSY FIND AMILABLE PRIOR TO COMPLETION OF CAL
SICIAN: MEDICAL CERTIFICATIO	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST DID TOBACCO USE CONTRIBUT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO HOSPITAL: 1 Pinpatlant 2	death but not resu	E OF DEATH 28. PI DOA 4 Nursing Hom	YES NO	PERFOI 1 VES 2 O Company one) 6 Other (Specify)	RMED?	24b. WERE AUTOPSY FIND AMILABLE PRIOR TO COMPLETION OF CAL OF DEATH?
PHYSICIAN: MEDICAL CERTIFICATIO	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST DID TOBACCO USE CONTRIBUT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Pinguillant 2 27. MANNER OF DEATH 1 Natural 5 Pending	OR AS A CONSEQUER death but not resu ETO CAUSE ER/Outpatient 3 1 INJURY 28	E OF DEATH 28. PI DOA OTHER: 4 Nursing Hore 18b. TIME OF 18c. INJ	YES NO	PERFOI 1 VES 2	RMED?	AMILABLE PRIOR TO COMPLETION OF CAL
ED BY PHYSICIAN: MEDICAL CERTIFICATIO	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST PART II. Other significant conditions contributing to d. DID TOBACCO USE CONTRIBUT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Pingetlant 2 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 28s. PLACE OF 2	death but not resu	E OF DEATH 28. PI DOA OTHER: 4 Nursing Hore 18b. TIME OF 18c. INJ	YES No	PERFOI 1 VES 2 O Company one) 6 Other (Specify)	INJURY OCCURED	24b. WERE AUTOPSY FIN AMAILABLE PRIOR TO COMPLETION OF CA OF DEATH? 1 YES 2 NO
MPLETED BY PHYSICIAN: MEDICAL CERTIFICATIO	If any, leeding to immediate cause. Enter UNDERIZ/ING CAUSE (Obsesse or injury that initiated events resulting in desth) LAST PART II. Other significant conditions contributing to DID TOBACCO USE CONTRIBUT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Pingular 2 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 28a. DATE OF (Month, Debut of Death) 28a. PLACE OF Building Investigation 3 Suicide 6 Could not be	death but not resu E TO CAUSE ER/Outpetient 3 1 INJURY 26 FINJURY — At home, ntc. (Specify) my knowledge, death of	E OF DEATH 28. PI DOA 4 Nursing Hors Sb. Time OF INJURY M 1 farm, street, factory, office occurred at the time, deta	YES No. ACE OF DEATH (Ch. No. 5 Raeldence URY AT NRK? YES 2 NO. e and place, and due	PERFOI 1 VES 2 O Ther (Specify) 28d, DESCRIBE HOW I City or Town, State) to the cause(a) and ma	INJURY OCCURED and Number or Rura	Ab. WERE AUTOPSY FINI AMILABLE PRIOR TO COMPLETION OF CA OF DEATH? 1 YES 2 NO
ED BY PHYSICIAN: MEDICAL CERTIFICATIO	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST DID TOBACCO USE CONTRIBUT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Pinpatlant 2 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 28. DATE OF (Month), De Juilding, of the best of Check only Centrified Physician: To the best of Check only Centrified Physician: To the best of Control Physician: To the best of the Control Physician: To the Control Physician: To the Death Physician: To the Death Physician: To the Death Physician: To the Death Physician: To the Death Physician: To the Control Physician: To the Physician: To t	death but not result of the second of the se	POPULATE SET SET SET SET SET SET SET SET SET S	YES No ACE OF DEATH (Ch. No. 5 Raeldence URY AT PRK? YES 2 NO e and place, and dua leath occured at the	PERFOI 1 VES 2 Deck only one) 6 Other (Specify) 28d, DESCRIBE HOW in City or Town, State) to the cause(s) and mailtime, date and placa, and ABER	and Number or Runi	Ald. WERE AUTOPSY FINI AMAILABLE PRIOR TO COMPLETION OF CA OF DEATH? 1 YES 2 NO RI Route Number, e(e) and manner as ater ED (Month, Day, Year)

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	OD ATTENDING DEVOCAME The law semiless that death configure he accorded with
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BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, hours after death with the State Dept. of Health and Mental Mygiene prior to buriat, cremation, or removal.	the medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760.	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a first death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fill bours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	Hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. OECEOENT'S NAME (First, Middle, Last, 2. DATE OF DEATH MONTH 3. TIME OF DEATH 11,1995 3:30A H February 4. SOCIAL SECURITY HUMBER 214-74-9888 6. AGE (In yrs. lest birthday)
YRS. 5. SEX 7. DATE OF BIRTH (Month Day, Year 9/24/ 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN 1 🗌 M 2 💢 F 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Charlestown Retirement Community Catonsville Balto. 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Balto Catonsville 1 YES 2 1 HO 100. STREET AHD NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 719 Maiden Choice Lane 21228 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—II yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. RACE — American indien, Black, White, atc. FORCES? 1 YES 2 1 Never Married 2 Merried BY 1 TES 2 HO Specify: 3 Wildowed 4 Divorced White B 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIHD OF BUSINESS/INDUSTRY (Specify only highest grade completed) COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S HAME (First, Middle, Maiden Sumeme) George Sakievich Anna Ukis BE 19e. IHFORMAHT'S NAME (Type/Print) 19b. MAILIHG AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Charles J. Tauter. Jr 4500 Ambermill Rd.21236 20a. METHOD OF DISPOSITIOH

1 X Burlel 2 Cremetion 3 Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE 4 Donation 5 Other (Specify) Most Holy Redeemer 2/16/95 Balto. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. HAME AHD ADDRESS OF FACILITY Leonard J. Ruck Funeral Home, Inc. Ulmale 5305 Harford Rd. Balto. Md. 21214 23. PART I. Enter the diecesee or compilectione that ceused the deeth. Do not enter the mode of dying, euch as cardiec or respiratory errest, ahock, or heart fellure. List only one ceuse on each line. Approximate Interval Between IMMEDIATE CAUSE (Finei Onset and Death Possible Pulming Emboliai m Myound INAIN. disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Athorleta cordis vonto Di sene CERTIFICATION Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate ceuse. Enter UNDERLYING Keunt Fr orbine CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Distetes Mellions PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AH AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS Company Hen & forling h. hel regury dat in AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only of EXAMINER? HOSPITAL: 1 YES 2 NO 1 Inpetient 2 ER/Outpetlant 3 DOA ursing Home 5 - Raeldence 6 - Other (Specify) 27. MAHHER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 28b. TIME OF IHJURY 28c. HJURY AT WORK? 28d. OESCRIBE HOW HJURY OCCUREO 1 Hetural 5 Pending 1 YES 2 HO ВУ Investigation 2 Accident 28e. PLACE OF IHJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATIOH (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 8 Could not be BE COMPLETED 4 Homicide 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAH: To the best of my knowledge, death occurred at the Hime, date end place, end due to the ceuse(e) end manner se stated. 2 MEDICAL EXAMIHER: On the besie of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGHED (Month, Day, Year)

Z - 11 - 95 29c. LICEHSE NUMBER IP. I Karrik NO D349571 0 30. HAME AHO ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Prigit). In he 100 Costmerelle MD 21228

July 22 AEGISTRAB'S SCHATORIL

- 3 Total Control of the Control of * BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last. 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR MARY CATHERINE WATTERS Februaru 995 12:00 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreig 213-38-676= Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH BALTIMORE MEDICAL CENTER DIRECTOR TOWSON BALTIMORE 10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY COCKEYSVILL 1 YES 2 NO permit. FUNERAL 101. ZIP CODE 21030 n and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit to burial, cremation, or removal. retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) ☐ Never Married 2 ☐ Married 1 TYES 2 NO Specify: BY wed 4 Divorced B 15. DECEDENT'S EDUCATION 18s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) SEAMSTRESS once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) ĕ UNKNOWN BE notified 19a. INFORMANT'S NAME (Type/Print) 2 315 nours after death. Page 6 may be pe METHOD OF DISPOSITION
Burlel 2 Cremation 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City must 3 □ 2-10 ZOVE CEM. Donation 5 - Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF 3 5 23. PARTA. Enter the disease, or complications that caused the daeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. the medical Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition SHOUL SEPTIC SHO event, resulting in death) executed GEVERALISED -71 TONITUS 5 110 RS traumatic CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate death certificate be signed by the attending physician Health and Mental Hygiene prior to PERFORATED cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated avents resulting in death) LAST Injury, or PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. requires that the MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? shows any 1 - YES 2 1 NO 1 | YES 2 | NO t. of h PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO IX UNCERTAIN WE this certificate has b with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one HOSPITAL OR ATTENDING PHYSICIAN: The Item HOSPITAL: OTHER: 1 | YES 2 | NO 1 Inpatient 2 - ER/Outpa 3 DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28c, INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO DAECTOR: After the BY Investigation 2 Accident 281. LOCATION (Street and Number or Pural Floute Number, City or Town, State) 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, atc. (Specify) 3 Suicide .00 ETED 8 Could not be 4 Nomicide determined 28 ADDRESON DELL. # Item 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(e) and menner as stated. COMPL (Check only one) On the basis of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner se stated. 296. SIGNATURE AND TITUELOF CERTS 2 E 8 BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 02092 2 7/91 2 30. MARKE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

MD

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6701 N Charles St.

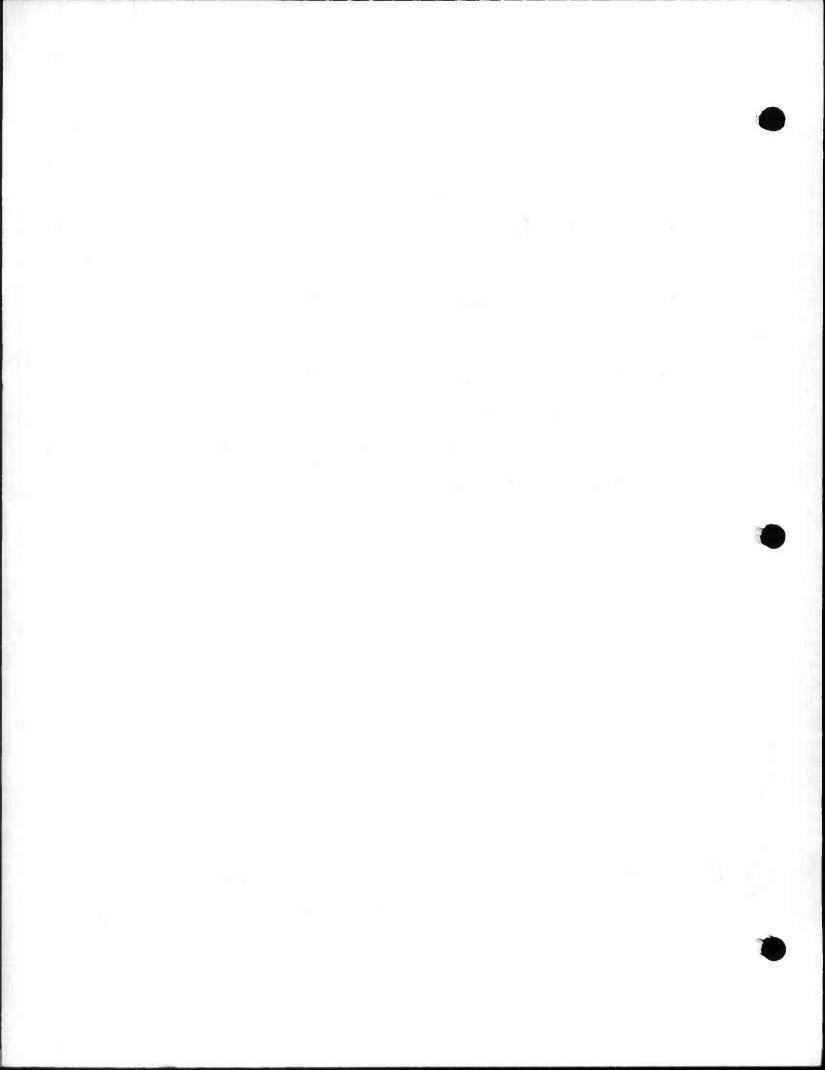
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MA ARGISTRAN'S, SIGNATURE

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MEN	TAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

			EPARTMENT OF HEALTH AND	MENTAL HYGIENE REG. NO.	
		1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY	YEAR 3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lost bi	rthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	FEBRUARY 5, 1	8. BIRTHPLACE (State or Foreign
should		544 38 3853 A 18 M 2 F 65 9a. FACILITY NAME (If not institution, give street and number)	YRS. MONTHS DAYS HOURS MIN.	(Month, Day, Year) FSB 22 19 29	(SicHiGAO
2, 3	CTOR	208 RING OF DECEDENT	96. CITY, TOWN OR LOCATION OF I		PRFORO
Pages 1,	ш	10a. STATE 10b. COUNTY	0c. CITY, TOWN OR LOCATION		10d. INSIDE CITY
permit. Pa	AL DIR	MARLANO HARTORO 106. STREET AND NUMBER	CHURCHY, LLE	100 (LIMITS? 1 YES 2 NO CITIZEN OF WHAT COUNTRY?
Sit	FUNERAL	208 RINFORTS DRIVE	2102	8	U.S.A.
	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARME FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	D 13. WAS DECENDENT OF HISP/ If yes, specify Cuban, Maxis 1 YES 2 NO Spec		14. RACE — American Indian, Black, White, atc. Specify:
or atte	ETED	(Specify only highest grade completed) (Give	DENT'S USUAL OCCUPATION kind of work done during most of working NOT use retired.)	16b. KIND OF BUSINESS/	INDUSTRY
ND hospits ached	COMPL	12YRS. byrs.		ISXIROD	FUEL SKEIZERS
YLA by the be deta	CO =	17. FATHER'S NAME (First, Middle, Last) EVERSTT WILLIAMS	18. MOTHER'S N	AME (First, Middle, Malden Surname)
AR ained thould	00		AILING ADDRESS (Street and Number or Rura	I Route Number, City or Town, State,	Zip Code) 2.1028
- 2 a a	2	KENSE WILLIAMS De	8 KINSFORIE D	PRIVE CHURG	CHVILL MARYLAND
TE S TS			DATE OF DISPOSITION (Name of ory or other place)	DATE 20c. LOCATION	— City or Town, Stata
ALTIM death. Page t funeral dire I. examiner	-1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		MOLITY OF BULFUR	C. P.A. 21000
	_	Mele 4 Zvano A	3 NEW PORT	DRIVE FOR	ON 11.14 12.25
hours after ed in by the or removal		23. PART I. Enter the diseases, or complications that caused the death ahock, or heart failure. List only one cause on each line.	. Do not enter the mode of dying, su	ch aa cardiac or respiratory	arrest, Approximate interval Between
thing 24 h etely filled emation, of, the		Total and the second se	E HEART	FARLURE	Onset and Death
66 / 60 ecuted with and complete burial, cre-	_	DUE TO (OR AS A CONSEQUE PULMÓNAV		2/5	540
OX 08 OX 08 ician and c rior to buri	ERTIFICATION	if any, leading to immediate	NCE OF):		1.60
ficate b physici ne prio	FICA	ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated exerts DUE TO (OR AS A CONSEQUE			10 1/C
ending Hygie	E	thet initiated events resulting in death) LAST	. O. J.		
the death by the attented Mental Frinjury, or	AL CE	PART II. Other significent conditions contributing to death but not resi	liting in the underlying cause given in	Part I. 24s. WAS AN AUTOPS	Y 24b. WERE AUTOPSY FINDINGS
	SCA	PROSTACE CANCER		PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
w requires that been signed of Health a	MEDIC				OF DEATH?
he law has be bept.	SICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH 25. WAS CASE REFERRED TO MEDICAL 26. PLACE C	YES NO UNCERTAL	N 🗆 📗	
SICIAN: The certificate the State	SIC	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 I	OTHER: DOA 4 Nursing Home 5 Rasidence	8 Other (Specify)	
NG PHYSIC fler this ce sath with th	ву рну	27. MANNER OF DEATH 1 Natural 5 Pending Investigation 28s. DATE OF INJURY (Month, Day, Year)	95. TIME OF INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJURY O	OCCURED
TTENDI TTENDI TTOR: A affer de	ETED B	3 Suicide 8 Could not be detarmined 28s. PLACE OF INJURY — At home, building, atc. (Specify)	farm, streat, factory, office	281. LOCATION (Street and Numb City or Town, State)	ber or Rural Route Number,
E 325 E	COMPLE	29s. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death one)			
HE HOSPITAL HE FUNERAL IN WITHIN 72 ORTANT. III		MEDICAL EXAMINER: On the basis of examination and/or inve	29c. LICENSE NU		the cause(s) and manner as stated. ATE SIGNED (Month, Day, Year)
SES	O BE	Juna VV	D31	175 F	7.1995
(-)		DR. JOAN P SOWARDS 21		AD FOLICE	N, MD 21047
		31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	L DECKIE NOI	TU, PALLS IC	DN, 1111) 21047
		FEB 1 5 1995 Julia Davidson Rendall			

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	OD ATTENDIAL DUVELCIAN: The last securities shae she death sections he assessed with

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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		STATE OF MARYLAND /	DEPARTMENT ERTIFICATION	OF HEAL	TH AND I		GIENE G. NO.				
	1. DECEDENT'S NAME (First, Middle, Lest) RUBY FEOTA W	lisner				2. DATE OF DE		YEAR	3. TIME OF DEATH		
	219-42-7364	SEX 6. AGE (In yrs. lest	YRS. MONTHS	DAYS HOU		7. DATE OF BIF (Month, Day, SCPT &		8. BIRTHP Country)	LACE (State or Foreign		
TOR	90. FACILITY NAME (If not institution, give street Overlea Gordens N RESIDENCE OF DECEDENT	Vursing Center		Balti		ATH	9c. COU	INTY OF DEA	ATH		
DIRECTOR	10e. STATE 10b. COUNTY	ltimore	10c. CITY, TOWN	OR LOCATION TY Hall	\				IOd. INSIDE CITY LIMITS? I YES 2 X NO		
FUNERAL	TION CITIES	ME		101. ZIP C	:00E .1236	>		IZEN OF WH	IAT COUNTRY?		
8≺	11. MARITAL STATUS 1 Never Married 2 Married 2 Wildowed 4 Divorced	. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 TYES 2 TYPE IF YES, GIVE WAR OR DATES	0	WAS DECENDER It yes, specify 0 1 PYES 2	Cuban, Mexicer	, Puerto Ricen,	ecify Yes or No-	Specify.	- American Indian, White, etc.		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade complete the complete that the	pleted) (Gh ille. ollege (1-4 or 5 +)	DEDENT'S USUAL Of the kind of work done Do NOT use retired.)	during most of w	orking		of Business/INI	DUSTRY			
BE CO	17. FATHER'S NAME (First, Middle, Lest) Thomas Clevelou	nd Davidson :	SR,		nother's had		Maiden Surneme)				
10	190. INFORMANT'S NAME (Type/Print) Maryano Testo		19b. MAILING ADDRESS (Street and Number or Rural Route Number, A Fox BRIER LANE								
	20a. METHOD OF DISPOSITION 1 Burlel 2 A Cremation 3 Removal from State 4 Donetion 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crematory or other place) Creen Mount Cemetery 20c. LOCATION — City of Cametery or other place) Creen Mount Cemetery								n, Stata		
	21. SIGN PUTEL OF FUNERAL SERVICE LICENII	Zavesh	E/		TARFO	Memo RD Rd	ries Balto.		1234		
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ehock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A FORSEQUENCE OF):										
RTIFICATION	Sequentially liet conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
PHYSICIAN: MEDICAL CER	PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED 1 YES 2 7 NO								YERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
SICIAN		OSPITAL:		TH (Check only one) ence 6 □ Other (Specify)							
B	1 statural 5 Pending Investigation 3 Suicide 6 Could not be	28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY — At hon	28c. INJURY A WORK? 1 YES	URY AT RES 2 NO 26d. DESCRIBE HOW INJURY OCCURED							
LETED	4 Homicide determined	building, atc. (Specify)			lace, and due	City or Town, State)					
O BE COMPLET	296. BIGNATURE AND TITLE OF EDITIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end pisca, and due to the cause(s) and manner se stated. 2 MEDICAL EXAMINER: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date end pisce, end due to the cause(s) end due										

29d. DATE SIGNED (Manth, Day, Year) 29c. LICENSE NUMBER will COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. RICHARD D'ANTONIO

31. DATE FILEPHANDED, DAY MAD 1995 32. REGIST

PEB 1 5 1995 32. REGIST ONIO 740 Towson

RICHARD D'ANTONIO, M.D. 7401 OSLER DRIVE, SUITE 201 BALTIMONE, MAINYLAND 21204 (301) 825-3416

(** C, CC C CC CL)

YEAR

1995

RE COUNTY OF DEATH

10g. CITIZEN OF WHAT COUNTRY? USA

Specify:

N/A

3. TIME OF DEATH

N. Carolina

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

YES 2 NO

Black.

Interval Between

Onset and Death

246. WERE AUTOPSY PRIDINGS

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TO THE HOSPITUL OR ATTENDING PHYSICIAN. The law requires that the death certificate be excused with TO THE FUNESHLA. DRECTOR: After this certificate has been signed by the attending objection and compare how finds within 22 focus after centally with the State Degr. or Health and Minital Hygiene prior to butcle, certified the MOSPITAINT. If Idean 28 is marked, or filem 28 shows any Injury, or other traumatic event	records that the death certificate be executed with the signed by the attending objection and compare the theath and findinal hygiene prior to burial, cre- tows any injury, or other traumatic event
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CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DOROTHY L. WRIGHT 2 10 4. SOCIAL SECURITY NUMBER S. SEX S. AGE (In yes, less birthday) F UNDER 1 YEAR F UNDER 24 HMS. T. DATE OF BIRTH 1726/1910 225-58-2846 DAYS HOURS. 1 M 2 50 F 84 YRS. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 8b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Granada Nursing Home Baltimore RESIDENCE OF DECEDENT tile, CITY, TOWN OR LOCATION 10s. STATE 10b. COUNT Baltimore Maryland permit. FUNERAL 101. ZIP CODE burlai-transit 3607 Forest Park Avenue 21216 hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES X NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 XNO Specify: BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married BY 3 X Widowed 4 Divorced use as the COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Skiw kind it work done during most of working the Do NOT use milred.) 166. KIND OF BUSINESS/INDUSTRY (Specify only highest grade or ä Elementary/Tiecondary (0-12) College (1-4 or 5 +) detached Domestic 9th 17. FATHER'S NAME (First, Addds, Last) retained by the 18. MOTHER'S NAME (First, Middle, Maidlen Surry 8 Ħ Thomas Johnson Emma Allen BE pade 5 should notified the, INFORMANT'S HAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 3607 forest Park Ave balto., Md. 21216 Luvenia E. Goodman Page 6 may be r 2 20a. METHOD OF DISPOSITION

1 Shurtal 2 Cramation 3 1 1

4 Donation 1 Other (Specify) 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must funeral director, Arbutus Memorial Park Arbutus, Maryland examiner FUNERAL SERVICE LICE 21. BIONATUR 22. NAME AND ADDRESS OF PACILITY death. LEROY O. DYETT & SON FUNERAL HOME t by the fi 4600 LIBERTY HEIGHTS AVENUE 21207 YOURS BIRTH medical Enter the disease shock, or hear to or complications that deseed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, are. List only one cause on each line. 数当 'n Blied IMMEDIATE CAUSE (Final # disease or condition cremation. of stonach Carcinoma completely event. resulting in death) DUE TO JOB AS A CONSEQUENCE OF recuted and con burier Billiaciny freet inspasion due to caronoma aj stonach traumatic CERTIFICATION Sequentially list conditions, physician if any, leading to immediate 2 cause. Enter UNDERLYING CAUSE (Disease or Injury prior Diebatos melling certificate other DUE TO (OR AS A CONSEQUENCE OF): that initiated events dilb resulting in death) LAST 6 death atte Mental Injury, 8 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? # MEDICAL 店員 100 M signed 1 THE 2 TOMO Health radumes shows Deen Deen 70 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 燕 Deer 23 3 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one ä Hem State certificate HOSPITAL O'THER:
4 Description of Tendence 6 Other (Specify) T YES 2 NO PHYSICIAN 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA ä 6 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Dey, War) 28c. INJURY AT WORK? 28b. TIME OF INJURY 284 DESCRIBE HOW INJURY DCCURED marked, the state t 🔲 Natural 1 YES 2 NO BY dist 2 Accident ATTENDING Affler 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) .00 3 Suitride 28f. LOCATION (Street and Number or Rural Route Number City or Teen, State) # Could not be COMPLETED arhar 28 i DIRECTOR 4 Humitride

STATE REGISTRAR

1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

25s. CERTIFTING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, 16st) 2/11/45 D30494 Belhmare MD RIRET DHMH-16 Rev 1/89

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296. SIGNATURE AND TITLE OF CERTIFIER

FEB 1

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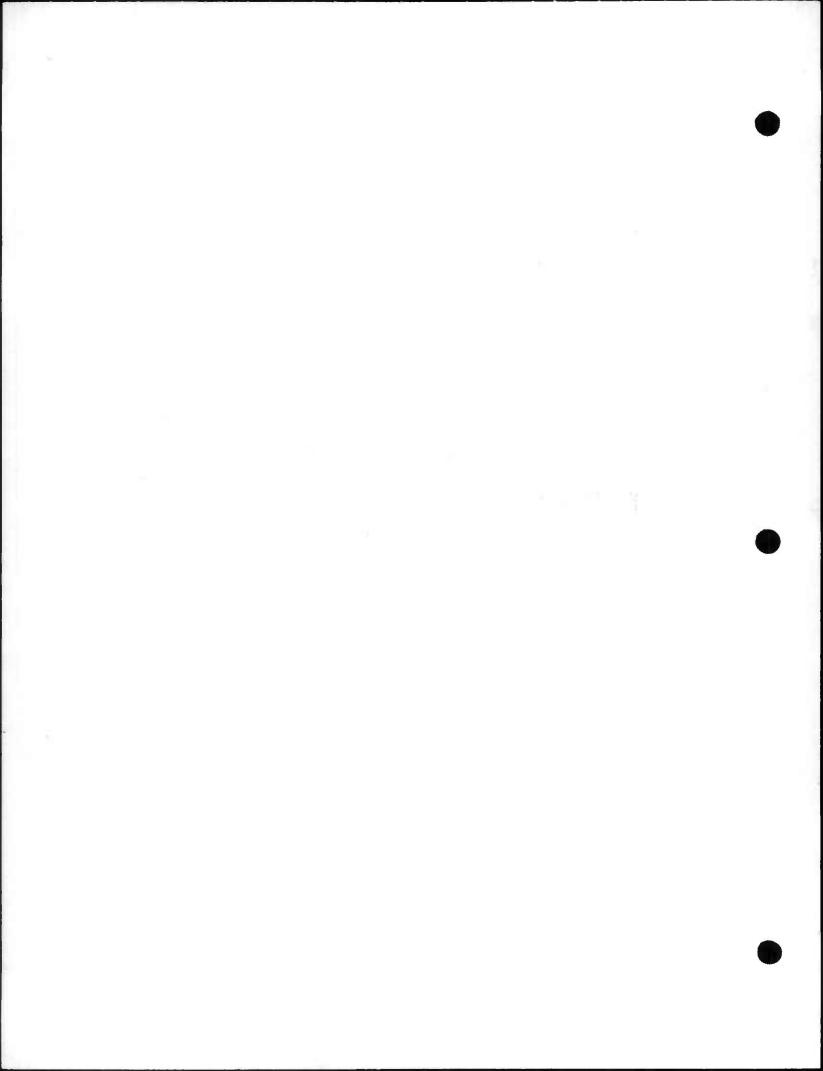
1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typs. Print)

32. REGISTRAR'S SIGNATURE

Julia Dhudson Raylall

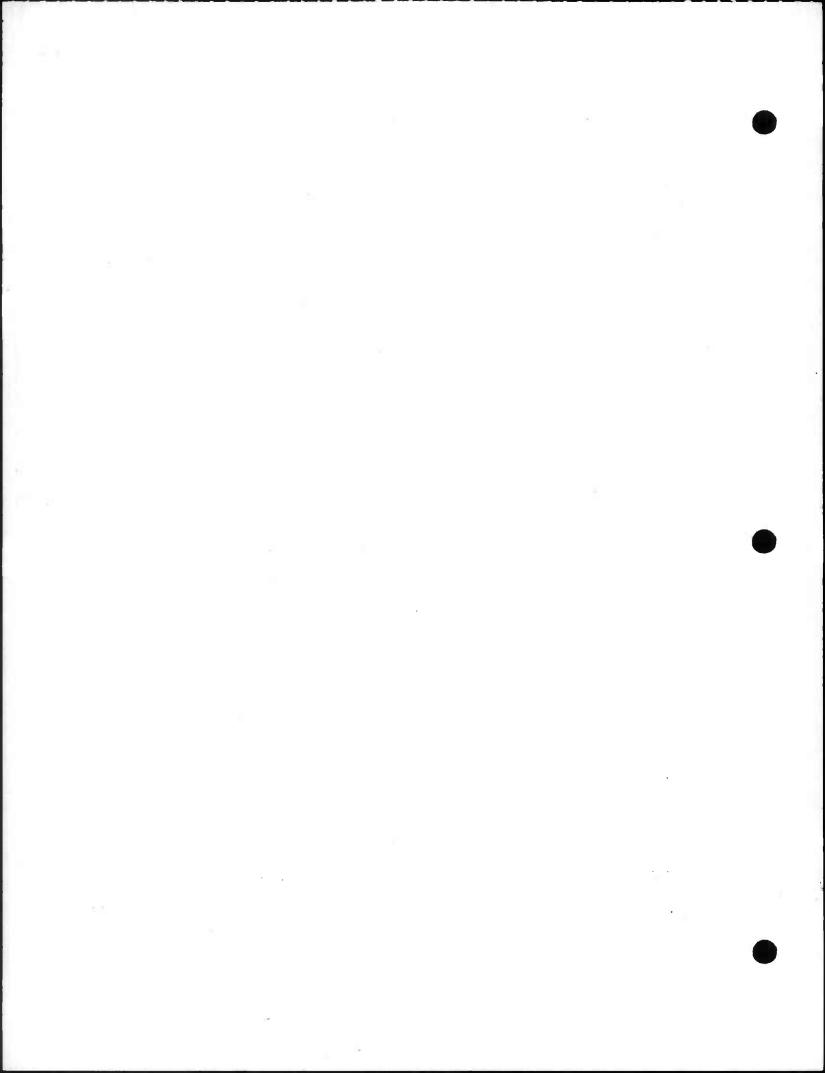
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2	CTOR A	urs after d	m 28	
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III WE HER	ST.	filed, with	PORTAL	
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	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPART			MENTAI	L HYGIEN					
NO.	1. DECEDENT'S NAME (First, Middle, Lest) LAKES I A	Wi'l	VIAM	WALL	ACC	2. DATE MONTH		10 9's	S. TIME OF DEATH 2:32 0 M			
3	4. SOCIAL SECURITY NUMBER 595-07-0714	5. SEX 6. AGE (In		IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	(Monti	OF BIRTH n, Day, Year) -27-	8.	BIRTNPLACE (State or Foreign Country)			
OR	98. FACILITY NAME (If not institution, give street and number) Johns Hopkins Bayara Med. Cfr- PAAN BALTA. 96. COUNTY OF DEATH											
DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY											
	m.d.		134	2/10					1 YES 2 NO			
FUNERAL	640 1317 Rt	Lett 19 VA	Times Tro-	1,000	2/2/8			10g. CITIZER	OF WHAT COUNTRY?			
FUN	11. MARITAL STATUS 1- Nover Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	If yes, sp	ENDENT OF NISPA	in, Puarto F			. RACE — American Indian, Black, White, atc.			
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT	res =	1 TYES	2 NO Specif	y:			BLACK			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	18a. DECEDENT'S US (Give kind of wor life. Do NOT use i	rk done during mo	ON st of working	16b.	KIND OF BU	SINESS/INDUS	TRY			
MPL	8 MGRAD	00.1092 (1-4 0) 3-7)	unkn	wen								
	17. FATNER'S NAME (First, Middle, Last)	Yor			18. MOTHER'S NA		Middle, Malden	Surname)				
TO BE	19a. INFORMANT'S NAME (Type/Print))	19b. MAILING AI		nd Number or Rural	Route Numb	per, City or Tox	n, State, Zip Co				
	20s. METHOD OF DISPOSITION	V 5 d N	PLACE AND DATE OF		TLe.TT	77 V	1	CF 8 4 /				
	# Burial 2 ☐ Cremation 3 ☐ Remote 4 ☐ Donation 5 ☐ Other (Specify)	oval from Stata ceme	tery, crematory or othe	r placey		2/1	1 2	indstance . md				
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE D 1.	77	1	les Flin		o ida	, >	DAL			
	23. PABY I. Enter the diseeeas, pr	emplications that caused	the daeth, Do not						Approximate			
	ehock, or heert feilure. iMMEDIATE CAUSE (Final	List Dniy one ceuse Dn ee	ch iine.						interval Between Onast and Death			
	disease or condition reaulting in death)	DISSEMINATION DUE TO (OR AS A C	ed Mycol	bacterio	al Avium	Co.	mplex		lyr			
NO	Sequentially list conditions,	LA CQUITED 1	mmunode	ficienc	y Synd	rome	_		2yr			
CATI	cause. Enter UNDERLYING		nunodefic		Virus				10 vc			
CERTIFICATION	CAUSE (Disease Dr injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE DF):		00							
	PART ii. Other eignificent condition	s contributing to death bu	t pot requiting in	the underlying	T cause abox in	Port i	24a. WAS AN	AITTORON				
JICAL		sting		tha oncerrying	g cause given in	rent I.	PERFOI	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE			
PHYSICIAN: MEDIC								7(OF DEATH? 1 ☐ YES 2 NO			
IAN	DID TOBACCO USE CONTR		B. PLACE OF DEATH		UNCERTAI	N XI						
YSIC	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outpet	tient 3 DOA 4		e 5 🗆 Rasidence	8 🗆 Other	(Specify)					
Y PH	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (Y WO	URY AT RK? 'ES 2 NO	28d. DE\$	CRIBE HOW	NJURY OCCUR	RED			
TED BY	2 Accident Investigation 3 Suicide 8 Could not be detarmined 28a. PLACE OF INJURY — At home, farm, strast, factory, office building, etc. (Specify) 28a. PLACE OF INJURY — At home, farm, strast, factory, office City or Town, State)											
BE COMPLETED		CIAN: To the best of my knowle										
E C0	296 SIGNATURE OF CENTIFIER			m my opinion, o	29c. LICENSE NUI		and piece, at		GNED (Month, Day, Year)			
TO B	30. NAME AND ADDRESS OF PERSON WHI		7//		J796	8		12/	12/95			
-	Kirsi Allison ME	DDiv 6	CON. WO	lfe JH	H Bal	huós	e m	0 212	205			
	31. TEB 1 5 1995	LA PORTERIOR PROVIDE	une all				-					



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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH SAMUEL WILSON 214 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Yea IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. MONTHS DAYS HOURS MIN 1 📈 M 2 🗆 F YRS. 212-20-4471 73 Oct 6, 1921 Maryland 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH IRECTOR Bon Secours Hospital Baltimore 10e. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY o Maryland Baltimore 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g CITIZEN OF WHAT COUNTRY? 2817 West Lafayette Avenue 21216 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Mexican, Puerto Rican, etc.)
 T YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY Specify: 3 Widowed 4 X Divorced World War II 18a. DECEDENT'S USUAL OCCUPATION

18a. DECEDENT'S USUAL OCCUPATION

18a. DECEDENT'S USUAL OCCUPATION

18a. DECEDENT'S USUAL OCCUPATION Black COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) College 5+ Professor Coppin State College 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Samuel H. Wilson, Sr. BE Rebecca Brent 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) ဥ 3410 HILLDALE Place Rebecca M. Johnson Baltimore, Maryland 21215 20s. METHOD OF DISPOSITION
1 X Burlel 2 Cremetion 3 Ramoval from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Feb 20c. LOCATION - City or Town, State Park Cem 17Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Pakway E. hullas Baltimore, Maryland 21216 23. PART I. Enter the diseases, or complicatione that caused the deeth. Do not anter tha mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart fellure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset end Death disease or condition resulting in death) Cardio Dy monary

Due to (OR AS/A CONSEQUENCE OF): Myocardial Inferction c Cardiovascular Disease CERTIFICATION Sequentially list conditions, If any, leading to immediate rteriosclerotic cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events reaulting in death) LAST PART-II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE home Obstructive hune DISEASE 1 YES 2 NO OF DEATH? Peripheral Vascular DISEASE 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES M NO UNCERTAIN PHYSICIAN: 25. WAS CASE-REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNED OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 281. LOCATION (Street and Number or Rural Route Number, City or Yown, Stete) 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 8 Could not be COMPLETED 4 Homicide 29a. CERTIFIER
(Chack only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end menner es stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER Internist 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) B a Hamilton MD Medical House O. D0829 TEB 12-1995 9

, M.D., Bon Secours Hospital

32. REGISTRAR'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Frank A. HAHLLTON

BALTIMUNE,

2000 W. Baltimoro St.

ours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 OR AT ENDING PHYSICIAN: The law requires that the death certificate be executed with DIMISION OF VITAL RECORDS, P.O. BOX 6876

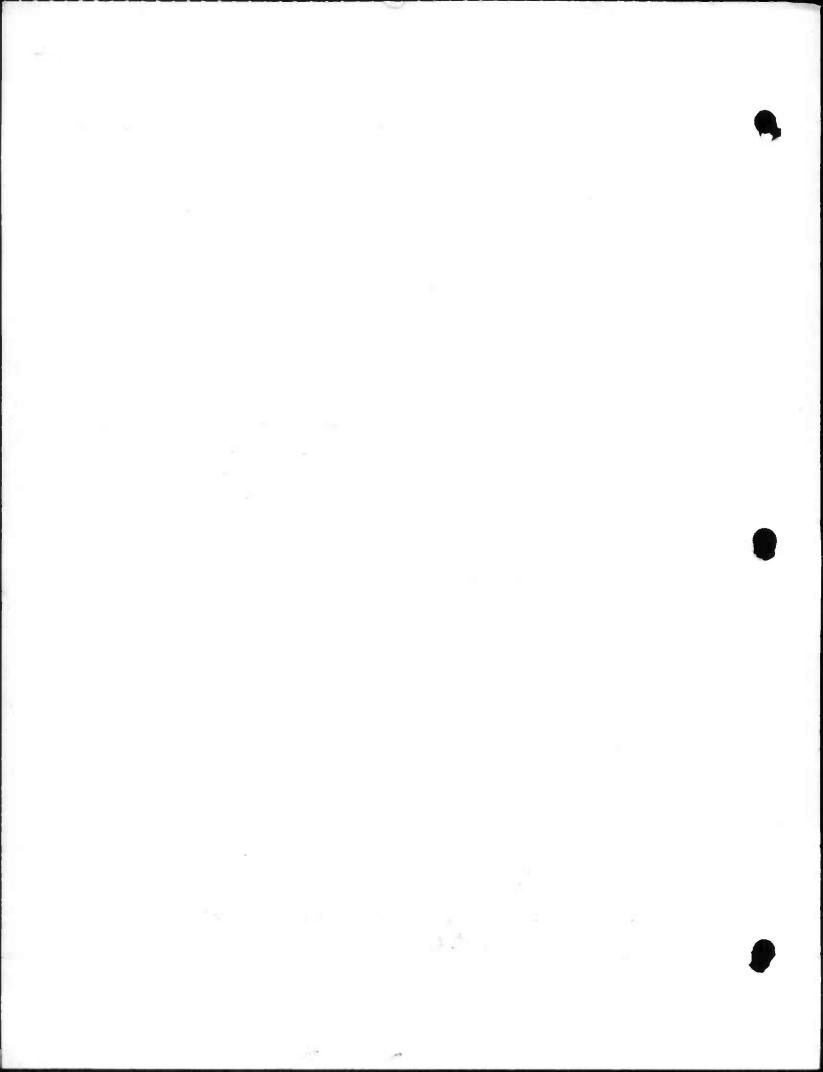
After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should need that the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

If 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3.								3. TIME OF DEATH								
	Edgar		W			Whit	take	er		Febru	ary I	lo, 1	.995	00:35 Am		
	4. SOCIAL SECURITY NUME		5. SEX 6. AGE (In yrs. lest		birthday)			IF UNCER		7. DATE OF BIRTH (Month, Day, Year)		6. BIRT		THPLACE (State or Foreign		
	216-36-2080		1 X M 2 □ F	93	YRS.	MONTHS	DAY\$	HOURS	MIN.	Feb 11		01	1	maica		
_	9e. FACILITY NAME (If not in	stitution, give s	treet and number)		i i	9b. CITY	, TOWN	R LOCATI	ON OF DE	EATH		9c. COU	NTY OF D			
DIRECTOR	Howard Coun	ty Gen	eral Hos	spital			01.ur	<u>mbia</u>				Но	oward	A		
[10e. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY		
5	Maryland	A	nn arund	le1		Sev	rern							LIMITS?		
A	10e. STREET AND NUMBER						101	. ZIP CODI	E			10g. CIT	IZEN OF V	WHAT COUNTRY?		
FUNERAL	933 Wieker	Road						2114	14			ι	JSA			
<u> </u>	11. MARITAL STATUS			IT EVER IN U.S. ARI		13.	WAS DEC	ENDENT C	F HISPAN	NIC ORIGIN? (S	pecify Yee	or No-	14. RACI	E — American Indian, k, White, etc.		
ВУ	1 Never Merried 2 X			VAR OR DATES	•			2 NO		n, Puerlo Rice y:	n, etc.)		Spec			
		EDENT'S EDUC	CATION	1 40 000										Black		
	(Specify only	highest grade	completed)	(Gir	CEDENT'S ve kind of v Do NOT us	vork done	during mo	on st of workin	פר	16b. KII	NO OF BUS	SINESS/IN(DUSTRY			
COMPLETED	Elementary/Secondary (0 Grade Schoo		College (1-4 or 5	+)	Self					7.7		T L				
8	17. FATHER'S NAME (First, M				err	EIIIDI	.Oyec		HER'S NA	ME (First, Midd	ortic		ırıst			
	Edward Whit	taker								n Tayl.		,				
BE	19e. INFORMANT'S NAME (7	ype/Print)		196	MAILING	ADDRESS	S (Street a			Route Number,		n, Stete, Zip	p Code)			
입	Arletta Whi	ttaker	•		33 Wi					ern, M			2113	33		
	20e. METHOD OF DISPOSITI		oval from State	20h PLACE A	NO DATE (OF DISPOS	NA MOLTIS	me of		- 475	200 100	CATION -	City or To	own, State		
	4 Donation 5 Other	(Specify)		cemetery, crer Arbutu	is Me	mor i	.a1. I	Park		Feb 15	Ba1	Ltimo	ore C	ce County, MD		
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE	1. 1		22.	NAME AN	D ADDRES	SS OF FA	ciuty Nu	ttor	ter Funeral Homes In				
	Hen	bert	٤. `	mutt	en	144	OT (2M A 115	ral	l.1.s Pa: cvland	cicway					
	23. PART i. Enter the di	seases, or c	omplications that	t caused the dea	ath. Do n	Dt enter	tha mo	de of dyl	ing, suci	h as cardiac	Dr raspi	ratory an	rest,	Approximats		
- 1	IMMEDIATE CAUSE (Fin		List Only One Cat	see Oil ascil lilla.										Onsst and Death		
	disease or condition resulting in death)	→ ,	Aspira	tion pne	umon:	ia								3 days		
				(OR AS A CONSEO												
8	Sequantially list conditi			OVASCULA:			nt							3 days		
RTIFICATION	if sny, leading to immed csuse. Enter UNDERLY!		DOE 10	ION AS A CONSEC	DENCE OF	·);										
윤	CAUSE (Disesse or inju that initiated events	7	DUE TO	(OR AS A CONSEO	UENCE OF	7:										
E	resulting in daath) LAS	T ,														
CE	DADT II Oabaa alaaliisa															
DICAL	PART ii. Other significa				eaulting i	n the ur	nderlylng	g cause g	givan In	Part I. 24	PERFOR		24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
	Gastrointe		r preedi	ng						1	YES 2	NO		COMPLETION OF CAUSE OF DEATH?		
Σ	Coagulopat													1 TYES 2 NO		
Ä	DID TOBACCO U		RIBUIE 10 CA		H YE			UNC	ERTAIN	4 D						
PHYSICIAN:	EXAMINER?	MEDICAL	HOSPITAL:			OTHER	۹:									
Ĭ	27. MANNER OF DEATH		26e. DATE OF	ER/Outpatient 3	28b. TIM	_	28c, INJ		aldence	6 Other (Sp 28d, DESCRI		I II IIIV OO	CURED			
	Netural 5	Pending	(Month, D	ay, Year)	INJ	URY M	WO	RK?	NO	200. DESCHI	BE HOW IF	NJURY OC	COMED			
Netural 5 Pending M 1 YES 2 NO 2 Accident Investigation 3 Suicide 6 Could not be 26e. PLACE OF INJURY — At home, tarm, street, factory, office 26f. LOCATION (Street and Number or Rural Route Number)								Route Number,								
COMPLETED	S Gould not be building, etc. (Specify) 4 Homicide determined building, etc. (Specify)															
Z	294. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the beat of	my knowledge, des	th occum	d at the t	lme, date	end place,	end due	to the cause() end man	ner ae stat	led.			
<u> </u>	296. CERTIFIEN 1 CERTIFIEN 1 CERTIFIEN PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the basic of axamination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner as a stated.) end manner se stated.							
								(Month, Day, Year)								
O BE	D32482 D2/10/95															
-	30. NAME AND SOORESS OF	PERSON WHO	COMPLETED CAUS	SE OF DEATH (ITEM	27) (Type,	Print)			, 0 20				J-/ .	,		
	Lynn D. Alon)., 2 Knc	oll North	n Dr.	., (Colu	nbia	, MD	2104	5			9		
	31. DATE FILED (Month, Day,		32. REGISTRA	R'S SIGNATURE												
	FEB 1 5 19	95 Ju	who will a find	or mandally												



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IAL	UNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.	be filed within 72 hours after death with the State Dept. of Health and N	INDOCTANT if from 20 is marked or liters 22 should not injured on other tenuments are the modified at any
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CERTIFICATION

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PHYSICIAN:

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

R.M. SHAH. M.D 31. DATE FILED (Month, Day, Year)

FFR

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32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MAMMAN 95 SARAH FEB -40 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign 214-26-1418 1 M 2 F 1-19-90. FACILITY NAME (If not institution, give street and number) CSCENT CHAPEL HILL CONVALCSCENT NYYSDING F 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH RANDALISTOWN. BALTIMORE Nurshing Home RESIDENCE OF DECEDENT 10e, STATE 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Baltimore Randallstown 1 YES 2 NO 100. STREET AND NUMBER 4511 Robosson Road Chapel Hill Nurs Home 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21133 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexicon, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 YES 2 NO Specify 3 Widowed 4 Divorced Black n.o16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elamentary/Secondary (0-12) College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State remetery, cremetory or other place) 3 - Removal from State 4 Donetlen 5 Other (Specify) in state 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W.Baltijmore St,Balto,MD21201 23. PARTA. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiratory arrest, Approximata shock, or haart failure. Liet only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel **Oneat and Death** diseese or condition resulting in death) OMOLTIPLE MYELOMA with Coaquiopathy Imonth rastro-Intestnal Bleeding due to a AND Sequentielly list conditions, ment oestalkagins & Gastrins and DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate IYEAR cause. Enter UNDERLYING CAUSE (Diseese or Injury a) and B). and Renal for DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditione contributing to deeth but not resulting in the underlying ceuse given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE Failure 1 TYES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpetient 3 | DOA ng Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 26b, TIME OF 28c. INJURY AT WORK? INJURY 1 Natural 1 YES 2 NO 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street end Number or Bural Route Number, City or Town, State) 3 Suicide 6 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) end manner es stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) R. m short ms D19668 ▶ 2-6-95

Reisterstown RD. OWINGS Mill MD. 21117

1 - FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF GEATH WHITE ADA 0438 1995 12 02 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 36356-30-2027 Country)VA (Month, Day, Year) 1 M 2 76 YRS. 18 02-06 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Liberty Med. Center Baltimore 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY
LIMITS?
YES 2 NO MD. Baltimore permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2324 Reistertown iours after death. Page 6 may be retained by the hospital or attending physician. If in by the funeral director, page 5 should be detached for use as the burial-transit 21216 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 NO If yea, specify Cuban, Maxican, Puarto Rican, atc.)

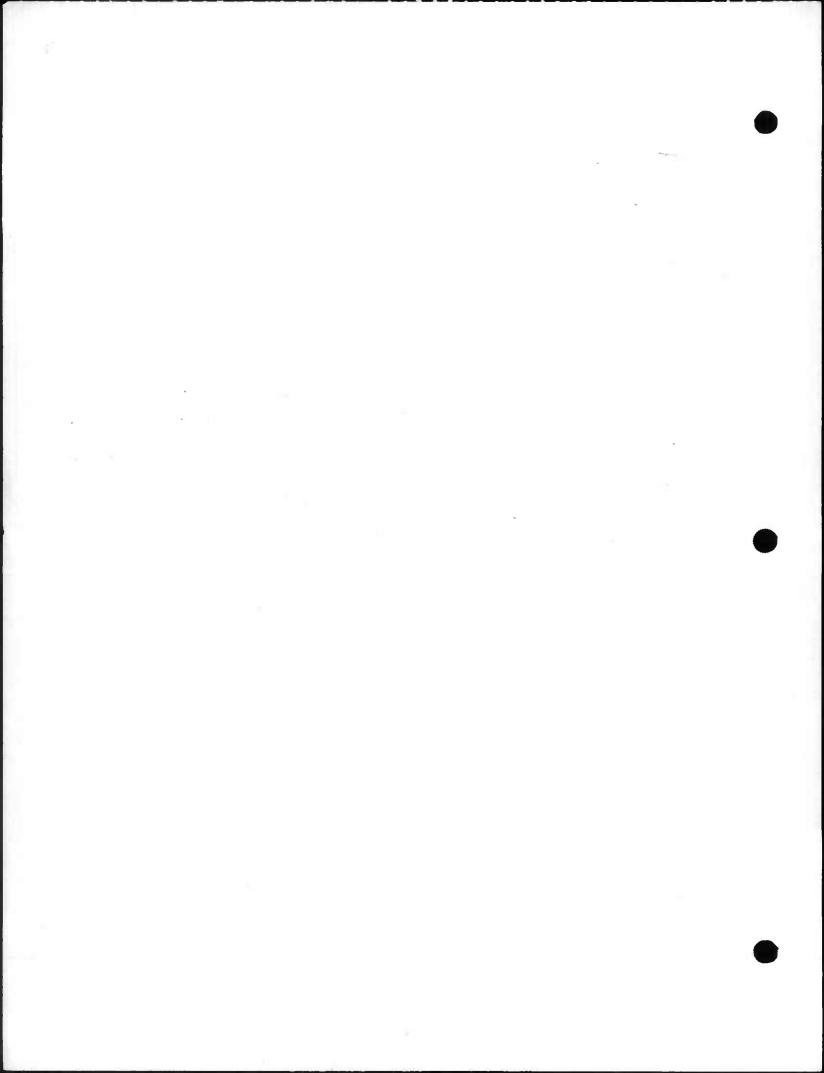
1 YES 2 NO Specify: 1 Never Married 2 Married Specify: Black BY 3 Wildowed 4 Divorced LEO I 15. OECEDENT'S EOUCATION 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Ш Elementary/Secondary (0-12) COMPL 8th Domet. once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Nelson Henderson Mary Henderson 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Napoleon R. White 2324 Reistertown Baltimore, MD. 21216 pe METHOD OF DISPOSITION

Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, Stata OATE must ■ Donation 5 □ Other (Specify). Cem. 2-16-95 Zion Lansdowne, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE the medical examiner 22. NAME AND ADDRESS OF FACILITY Albert P. Wylie F/H PA 638 N, Gilmor ST. 21217 een signed by the attending physician and completely filled in by the of Health and Mental Hygiene prior to burial, cremation, or removal. 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert feliure. List only one cause on each line. Approximate interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) Sepsus 20 neumania event. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within OUE TO (OR AS A CONSEQUENCE OF): esperalizy failure traumatic CERTIFICATION Sequantially list conditiona, DUE TO (OR AS A CONSEQUENCE OF) if any, laeding to immedieta nd Stage Rev DUE TO (OR AS A CONSEQUENCE OF): cause Enter UNDERLYING CAUSE (Disesse or injury injury, or other that initiated events reaulting in daeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? PERFORMED? shows any 1 TYES 2 NO has been s Dept. of H 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate ha with the State D irked, or Item EXAMINER? HOSPITAL:
1 Ainpetiant 2 ER/Outpetient 3 DOA OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) 1 WES 2 NO 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Neturel 2 Accider 1 YES 2 NO ВҮ After 1 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is 8 Could not be DIRECTOR: / COMPLETED 4 Homleide detarmined item 29a CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner as stated. THE HOSPITAL C THE FUNERAL D filed within 72 h TO THE HOSPITAL

TO THE FUNERAL

Be filed within 72 h

IMPORTANT: If I 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Med. House V 45682 D2-12-95 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type 2600 Liberty BIKKAM Avenue AND 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE FEB 1 5 1995 02-12-9



NN The law requires that the death certificate be executed withings hours after death. Page 6 may be retained by the hospital or attending physician.

State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Them 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 AN The aw requires that the death certificate be executed within VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL ON FENCE TO THE FUNERAL DINIGORIE De filed within 72 non 28 to IMPORTANT: 16 tonn 28 to

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F	OR				STATE OF	MARY	LAND	/ DEPART	MENT OF	HEALTH	AND ME	NTAL	HYGIENE
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	REGISTRAR		CERTIFIC	CATE OF	DEATH	REG.	NO.		
		FLLEN		BITY		2. DATE OF DEAT MONTH	H DAY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. S 215-68-7617 1	SEX 6. AGE		IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yes 3-3-19)	ar)	Count	HPLACE (State or Foreign ry) RYLAND
- 1	9a. FACILITY NAME (If not institution, give street a	nd number)		9b. CITY, TOWN	OR LOCATION OF OR			NTY OF D	
DIRECTOR	CARROLL COUNTY GENER	RAL HOSPITA	AL	WE	STMINSTE	3		CARI	ROLL
EC	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCA	TION				10d. INSIDE CITY
E	MARYLAND PRI	NCE GEORG	E	T,A	UREL				LIMITS?
AL	10e. STREET AND NUMBER				f. ZIP CODE		10g. CIT	IZEN OF	WNAT COUNTRY?
FUNERAL	1125BEAL L PLACE 112	5 Beall Pla	ce		20707			USA	
5		WAS DECEDENT EVER I FORCES? 1 YES	N U.S. ARMED	13. WAS OF	CENDENT OF HISPAN	IIC ORIGIN? (Specifi	y Yee or No-	14. RACI	E — American Indian, k, Whifa, atc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D		1 🗆 YES	2 XNO Specify	r.	,		//y: WHITE
ם	15. DECEDENT'S EDUCATIO (Specify only highest grade comp	N leted)	16e. DECEDENT'S U (Give kind of wo	ork done during m		18b. KINO OF	BUSINESS/IN	OUSTRY	
COMPLETED	Elementery/Secondery (0-12) Col	llege (1-4 or 5+)	DINNING	,	темь лит		FOOD		
W	17. FATHER'S NAME (First, Middle, Lust)	P	DIMITING	KOON AI		ME (First, Middle, Ma			
	ANTHONY P. ZUKASKY					VASENCE			
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DORESS (Street	and Number or Rural F	Route Number, City or	Town, State, Zi	p Code)	
2	HELEN Y. ZUKASKY		1125 B	EALL PL	ACE, LAU	REL, MAR	YLAND :	2070	7
	20a. METHOD OF DISPOSITION 1 \$\infty\$ Burlal 2 \$\subseteq\$ Cremation 3 \$\subseteq\$ Ramoval f 4 \$\subseteq\$ Donation 5 \$\subseteq\$ Other (Specify)	rom Stata cen	o. PLACE AND DATE OF netery, crematory or oth VY HILL C	er niacel		2/14	LOCATION —		
	21. SIGNATURE OF FUNERAL SERVICE LICENSE				ND ADDRESS OF FA				HOME, INC.
	1 (dala)	Dato				RING ROA	D, LAU	REL,	MD 20707
	23. PART I Enter the diasses, or composition of shock, or heart fallure.	only one chuse one	d the desth. Do no	ot enter the me	ode of dying, such	ss cardisc or n	espiratory sr	rest,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disesse or condition	A 0:	1	r. Air	Part	Ţ.,	- 10		Onset and Death
	resulting in death)	KMOXI		ayoho	MACHEN	44 2			12 Now
_		C DIÀ MA	CONSEQUENCE OF)	whole	1. 15/1	DO A	eria		22.1101
5	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	CONSEQUENCE OF)	\ \ \	, -/	ion ;	Λ	7.	52 yran
8	cause. Enter UNDERLYING CAUSE (Disesse or Injury	U keede	us m	alle	Mual	con >	Mase	Les	n d
CERTIFICATION	that initiated eventa resulting in death) LAST	DUE TO (OR.AS	CONSEQUENCE OF)	10	alisia				82110-1
H	d.	Julian	, a	(& Lo	The Contract				32900
	PART II. Other aignificant conditions con	ntributing to dasth t	out not resulting in	the underlyin	g cause given in	Part I. 24a. WA	S AN AUTOPSY	24b	. WERE AUTORS FINDINGS
DICAL	mingh 1	act u	redu	21			S 2 MO		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME	0 ,		Δ				7		1 YES 2 (100)
ä	DID TOBACCO USE CONTRIBU	JTE TO CAUSE C	FEATH YES	□ NO [UNCERTAIN	4 🗆			
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	SPITAL:	28. PLACE OF GEATH	(Check only one)					
YS	1 YES 2 NOO 1	Inpatient 2 - ER/Out	petlant 3 DOA	t ☐ Nursing Hor	na 5 🗆 Realdenca				
4	Natural 5 Pending	(Month, Day, Year)	28b. TIME INJU	RY W	JURY AT DRK?	28d. DESCRIBE H	OW INJURY OC	CURED	
9	2 Accident Investigation 3 Suicide & Could get be	28a. PLACE OF INJURY	— At home, farm, atr		YES 2 NO	281. LOCATION (St	met and Numbe	c or Burni I	Boute Number
8	4 Homicide determined	building, etc. (Spe-	cily)	,		City or Town, S		or Horar I	tone Humber,
COMPLETED BY PHYSICIAN:	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN:								
ဗ		the basis of exemitatio	n and/or investigation.	in my opinion, i					
TO BE	29b. SIGNATURE AND TITCE OF CERTIFIER	MD	10		29c LICENSE NUN	1915	29d. OAT	2/1	(Month, Day, Year)
-	30. NAME AND ADDRESS OF PERSON WHO COM	MPLETED CAUSE OF DE	ATH (ITEM 27) (Type, F	WAS	H	Rd	Wex	hu	uster ND
	31. DATE FILED (Mooth, Day, thar)	M. REGISTRAN'S SIGN	Association .	, ,	-		- 0		
	()		- 1					_	OHMH-16 Rev 1/89

020	physician	d for use as the burial-transit
15-0	ttending	as the
212	0	for use
ND	le 6 may be retained by the hospital	etached
YL	by the	d be de
MAR	retained	frector, page 5 should be detached
Ж, I	lay be	page
MOR	аде 6 п	director,
BALTIMORE, MARYLAND 21215-0020	death. P	in by the funeral di
m	after (by the
	Ours	=

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The Jaw requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached		IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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res	igne	ealth	50
requi	en s	H JO	shov
AR!	3S be	lept.	23 \$
The	ite ha	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	E
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PH	#	h wi	arke
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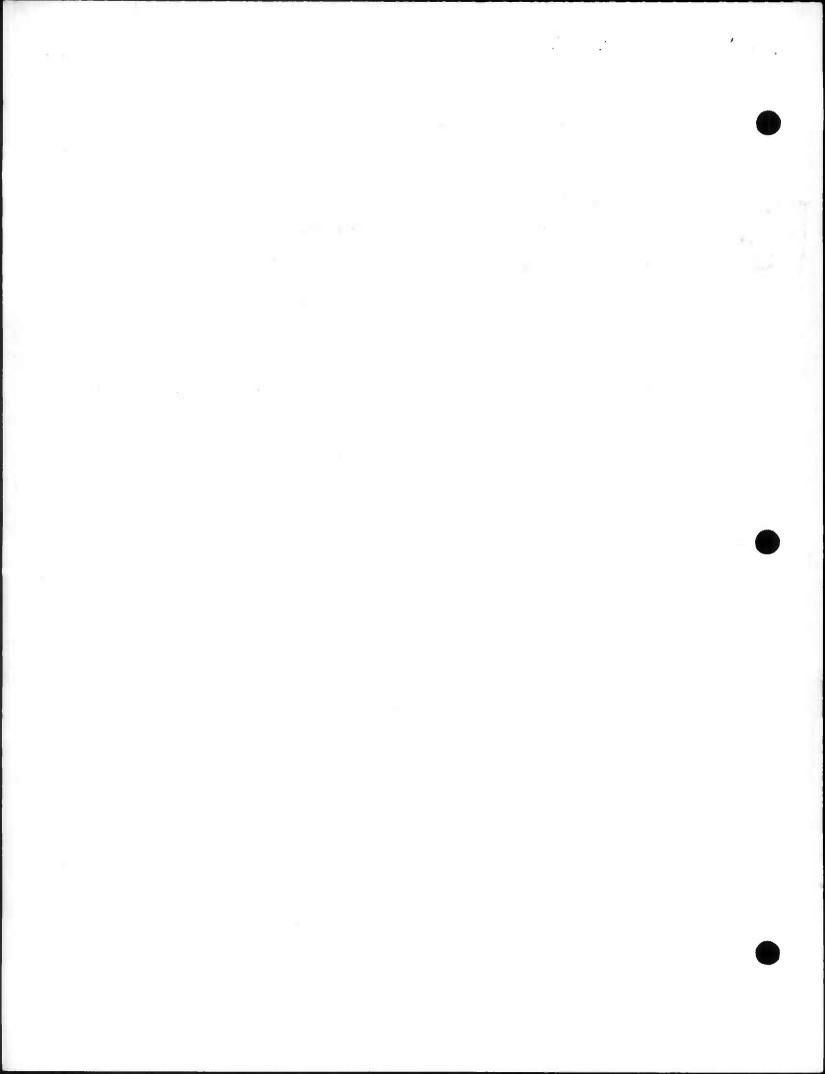
	1 - STATE REGISTRAR		CE		ICATE O				EG. NO	_		
	1. DECEDENT'S NAME (First, Middle, Lest)							2. DATE OF C	DEATH	AY	WEAR	3. TIME OF DEATH
	RONALD	D.	ADKIN	S				N.twu 4	_	27.19	YEAR	22/1 M
	The second secon	. SEX	8. AGE (In yrs. lest	birthday)	IF UNDER 1 YEAR	IF UNDER	-	7. DATE OF 8 (Month, De)	(RTH		8. BIRTH	IPLACE (State or Foreign
	213-60-9053	M 2 □ F	41	YRS.	MONTHS DAYS	HOURS	MIN.	June 1	4,	1953	Ma	ryland
	9e. FACILITY NAME (If not inetitution, give street	and number)			9b. CITY, TOWN	OR LOCATE	ON OF DE	EATH		9c. COU	NTY OF D	
DIRECTOR	PENINSULA REGIONAL	MEDICA	L CENTER	2	S	LISBU	IRY			พา	COMI	CO
5	RESIDENCE OF DECEDENT											
E	_	icomico	i	10c. CIT	Y, TOWN OR LOC	_{ATION} itlan	a					10d, INSIGE CITY LIMITS?
	Maryland W.	TCOULTCO										1 X YES 2 NO
RA	502 Forest Drive				1	of. ZIP CODI	€ 1826			10g. CIT		WHAT COUNTRY?
FUNERAL											0.5	D.A.
	1 Never Married 2 Merried	FORCES? 1	T EVER IN U.S. ARM	MED O				NIC ORIGIN? (Sp in, Puerto Rican		or No—	14, RACE Black	E — American Indian, k, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		1 🗆 YI	\$ 2 X NO	Specify	y:			Speci	White
0.	15. OECEDENT'S EDUCATI	ION	16a. DEC	EOENT'S	USUAL OCCUPAT	ION		16b. KINI	D OF BU	SINESS/INC	DUSTRY	VIII 00
	(Specify only highest grade con Elementary/Secondary (0-12)	npleted) College (1-4 or 5 +	(Gh	e kind of	work done during r se retired.)	nost of working	ng					
립		Years		ecto	r			Techi	nica	1 & 0	Comm	unity Service
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	1				18. MOTI	HER'S NA	ME (First, Middle	_			
BE (Norman L. Adkins					M	ary	Gay Ree	ese			
2	19e. INFORMANT'S NAME (Type/Print)		19b.	MAILING	ADDRESS (Street	and Number	or Aural F	Route Number, C	ity or Tow	n, State, Zip	Code)	
F	Lynn Adkins (Wife)		5	02 F	orest D	rive	- Fr	uitland	d, M	D :	21826	5
	20e. METHOD OF DISPOSITION 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removal	from State	20b. PLACE A	ND DATE	OF DISPOSITION (lame of		OATE	20c. LO	CATION -	City or To	wn, State
	4 Donation 8 Other (Specify)		Rehobe	th P	resby.				5	Rehol	beth,	, MD
	21. SIGNATURE OF PURERBL SERVICE LICENS		· Con	/		Hate &		aury Is Fune:	ra 1	Homo		
	Robert H. Bra		Jr.	1				Cris			VID ′	21817
	23. PART I. Enter the diseases, or com	plications that	caused the dee	th. Do r	not enter the m	ode of dy	ing, auci	h as cardiac	or respi	ratory an	rest,	Approximate
	SHOCK, OF HEART TAHUTE. LIST	only one caus	se on eech line.									interval Between Onset and Daath
	disease or condition resulting in death)	Ami	yotroph	310	Late	$m \mid$	Sc	leros	217			Syears
ı	Tooding in coatily	DUE TO	OR AS A CONSEQ	UENCE O	F):			1	-			3 9 00 3
Z	Segmentially list and datas. b											
	Sequentielly list conditions, If any, leading to immediate	OUE TO	(OR AS A CONSEO	UENCE O	F):							
를 	CAUSE (Disease or Injury	OUE TO	/OR 10 1 0000000									
	that initiated events resulting in death) LAST	002 10 (OR AS A CONSEQU	UENCE OI	F):							İ
CERTIFICATION	d											
4	PART II. Other significent conditione conditione	ontributing to	deeth but not re	sulting	in the underlyl	ng ceuse g	given in	Part I. 24e.		AUTOPSY	24b.	WERE AUTOPSY FINDINGS
DICAL	preumonitis	hy	POXIC	CA	cephalo	spath	4		PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME		, ,				,	/					OF DEATH?
÷ l	DID TOBACCO USE CONTRIB	UTE TO CA	USE OF DEAT	'H YE	S NO	JUNC	ERTAIN	V Z				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE	OF DEAT	TH (Check only on							
Š	TI TI	OSPITAL:	ER/Outpatient 3	DOA	OTHER:	me 5 🗆 Re	sidence	8 Other (Spe	icffy)		_	
£	27. MANNER OF DEATH	28e. DATE OF (Month, Da		28b. TIM		JURY AT		28d. DESCRIB	E HOW I	NJURY OC	CURED	
BY	Natural 5 Pending 2 Accident Investigation	(Month, Da	sy, toury	ING		YES 2	NO					
	3 Sulcide 6 Could not be	28e. PLACE OF	F INJURY — At hometc. (Specify)	o, farm, s	treet, factory, off	ce		281. LOCATION	(Street a	and Number	or Rural R	loute Number,
2	4 Homicide determined		oral (opcony)				- 1	City or Tox	m, State)			
2	29a. CERTIFIER Check only	: To the best of	my knowledge, deat	th occurre	ed at the time, da	a end place,	, end due	to the cause(e)	and mer	mer as stat	led.	
COMPLETED	one) 2 MEDICAL EXAMINER: 0) end menner se stated.
	296. SIGNATURE AND TITLE OF CERTIFIES	/				29c. LICE	NSE NUM	/BER		29d. DAT	E SIGNED	(Month, Day, Year)
) BE	Charl Min	1/1				1		0853		I	10-	195
2	30. NAME AND AGORESS OF PERSON WHO CO	OMPLETED CAUS									1	113
	Charles B. S	silvia	Jr 1	10	P	RMC		54	-L I	1 Ru	ny	mD 2180/
	FEB 0 1 1995 Julia	A2. REGISTRAP	SIGNATURE									

JAN 25 1995

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-libe filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or remoral. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1	_	FOR STATE REGISTE		STATE	0F	MARYLAND	
		REGISTE	IAR				ERTIF

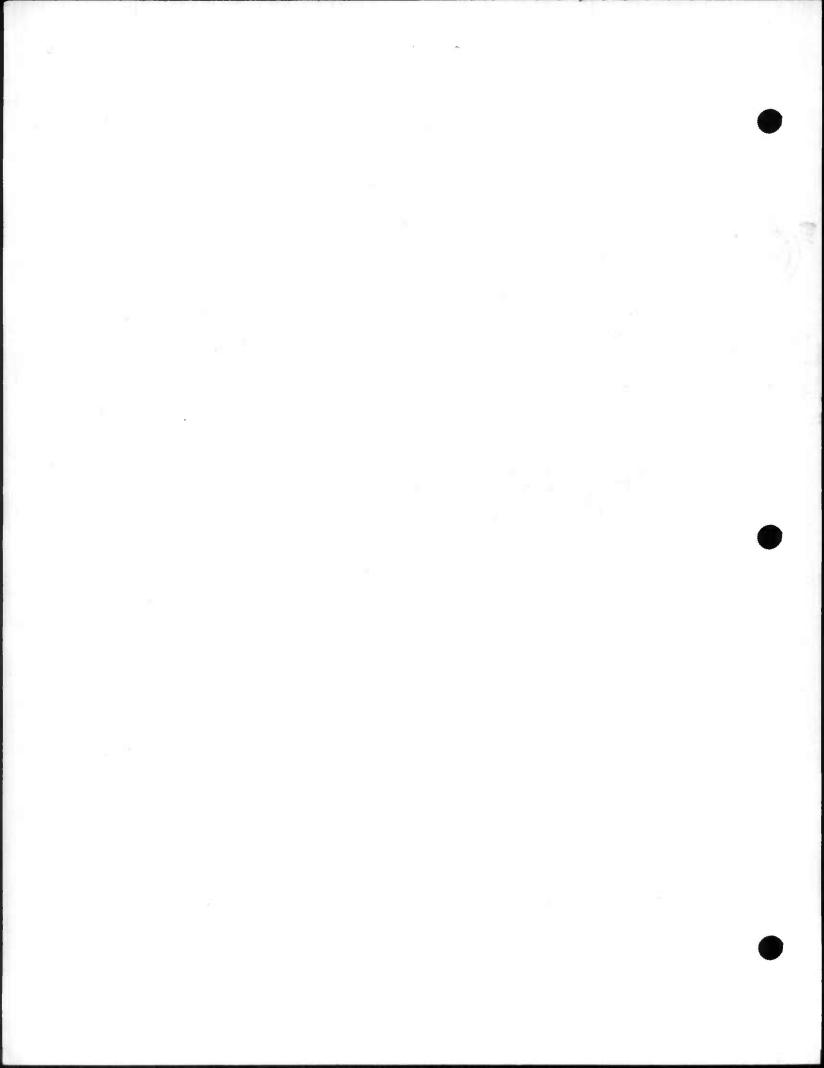
	1 - FOR STATE REGISTRAR	STATE OF MARYLAND		TMENT OF			NTAL HYGIEN			
1	1. DECEDENT'S NAME (First, Middle, Last)					2.	DATE OF DEATH	AY	WEAR	3. TIME OF DEATH
		ayne Andrews					an. 24		95	7:30 A M
1		6. SEX 6. AGE (In yrs.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 H	IIN.	DATE OF BIRTH (Month, Day, Year)		Count	
	215-44-6993 1 9a. FACILITY NAME (if not institution, give stree	M 2 F 48	YRS.	9b. CITY, TOWN	OD LOCATION A	_	ay 18,	194	NTY OF D	Maryland
TOR	SALISBURY NURSING &		2	SALISBU					COMIC	
DIRECTOR	10a. STATE 10b. COUNTY	omico		y, town or Loca rsonsb						10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 7461 Rachel I	Lane		10	or. ZIP CODE	849			J.S.	WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1	2. WAS DECEDENT EVER IN U.S. FORCES? 1 1 YES 2 1 IF YES, GIVE WAR OR DATES	ARMED	If yea, s		laxican, Pu	RIGIN? (Specify Yes serto Rican, stc.)	n or No—	14. RACI Blac Spec	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co	rion 18a. mpleted) College (1-4 or 5 +)		USUAL OCCUPATI work done during m se retired.)			16b. KIND OF BU	SINESS/INC	OUSTRY	white
MPL	8 17. FATHER'S NAME (First. Middle, Last)		Carpe	ntry	1		carpe		7	
BE CC	Joshua H. Andre	ews					First, Middle, Meiden Merrit		ndre	ews
2	190. INFORMANT'S NAME (Type/Print) Emma Jane Andre	ews					Number, City or Tow arsonsh			3 21849
	20a. METHOD OF DISPOSITION 1 Surial 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)	20b. PLAC	CE AND DATE (OF DISPOSITION (N	eme of		DATE 20c. LO	CATION -	City or To	
	21. SIGNATURE OF FUNERAL SERVICE LICEN		angn.	ill Cer	ND ADDRESS O			JIEG.	recr	ee, Ma.
	Patricia .	I. Denne	0	Denn:	is Fun	era	l Home,	Snov	v Hi	.11,Md.
	23. PART I. Enter the diseasee, or con	nplications that caused the	deeth. Do r	ot enter the me	ode of duing	erich ee	cardiac or resp	catory an	est.	Approximate
- 1	 snock, or heart failure. Lis 	it only one cause on sech li	ine		ode or dynig,	BUCII #5	оштана от тоор	y a	,	
	shock, or heart failure. Lis	t only one cause on sech li	ine.					y a	,	Interval Batween Onset and Death
NC	iMMEDIATE CAUSE (Finel disease or condition resulting in death)	Hepatic Due to (or as a cont ADVANCEX	ENC SEQUENCE OF	epla IRRI	COPAT	ily				Interval Batween
CATION	shock, or heert failure. Lie iMMEDIATE CAUSE (Fine) disease or condition recuiting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CONI	SEQUENCE OF	epla IRRI OL use	COPAT 10 Scs	ily				Interval Batween
ERTIFICATION	shock, or heer failure. Lis iMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONTROL OF AS	SEQUENCE OF	epla IRRI OL use	COPAT 10 Scs	ily				Interval Batween
AL CERTIFICATION	shock, or heert failure. Lis iMMEDIATE CAUSE (Fine) disease or condition reculting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that inliteted events resulting in death) LAST PART ii. Other eignificent conditions of	DUE TO (OR AS A CONTINUED DUE TO (OR AS A CONTINUED DUE TO (OR AS A CONTINUED DUE TO (OR AS A CONTINUED TO (OR AS A CONTINUED TO (OR AS A CONTINUED TO death but no	SEQUENCE OF	epla nRRI nol use	LOPAT LO Ses	ily	- × (7)	yens	2-3	Interval Batween
4	shock, or heert failure. Lis iMMEDIATE CAUSE (Fine) disease or condition reculting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that inliteted events resulting in death) LAST PART ii. Other eignificent conditions of	DUE TO (OR AS A CONTENT OF TO (OR AS A CONTEN	SEQUENCE OF	epla nRRI nol use	LOPAT LO Ses	ily	- × (7)	Y EAT	2-3	Interval Batween Onset and Death (MovTel (7 Sparks) Were AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
4	shock, or heert failure. Lis iMMEDIATE CAUSE (Fine) disease or condition reculting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that inliteted events resulting in death) LAST PART ii. Other eignificent conditions of	DUE TO (OR AS A CONTENTION OF AS	SEQUENCE OF	epla nRRI nol use	COPATION SCA	illy 3We	i. 24a. WAS AN PERFOR	Y EAT	2-3	Interval Batween Onset and Death (MaNTAL (7 YEARS) WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE
4	shock, or heert failure. Lie iMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificent conditions of ATTUAL DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	DUE TO (OR AS A CONTINUED TO CONTINUED TO COR AS A CONTINUED TO COR AS A CONTINUED TO CONTINUED TO CONTINUED TO CONTINUED TO CAUSE OF DECORPITAL:	SEQUENCE OF DEATH YE	Epsla- Fine Lange In the underlying In (Check only one, OTHER:	COPATION SCALE	TAIN E	i. 24a. WAS AN PERFOR	Y EAT	2-3	Interval Batween Onset and Death (MovTel (7 Sparks) Were AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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	shock, or heer failure. Lie iMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that inhiteted events resulting in death) LAST PART II. Other eignificent conditions of the condit	DUE TO (OR AS A CONTINUED TO (OR AS A CONTIN	SEQUENCE OF DEAT 3 DOA INJ	In the underlying the form one of the control of th	COPATION OF THE PROPERTY OF TH	TAIN E	i. 24a. WAS AN PERFOR 1 YES 2 Other (Specify) I. DESCRIBE HOW I	AUTOPSY MED?	2 4b	Interval Batween Onset and Death (MovTel (7 Years) WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL	shock, or heert failure. Lie iMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST PART II. Other eignificant conditions of the cause of	DUE TO (OR AS A CONTINUED TO (OR AS A CONTIN	SEQUENCE OF DEAT 3 DOA INJ	In the underlying the form one of the control of th	COPATION OF THE PROPERTY OF TH	TAIN E	i. 24a. WAS AN PERFOR	AUTOPSY MMED?	2 4b	Interval Batween Onset and Death (MovTel (7 Years) WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL	shock, or heert failure. Lie iMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST PART II. Other eignificant conditions of the condi	DUE TO (OR AS A CONTINUED TO (OR AS A CONTIN	SEOUENCE OF DEAT 128b. TIME INJ. death occurrence of the communication	CP SLA- FI: CRC L FI: CAL USE FI: In the underlyin IN (Check only one, OTHER: 4 Nursing Hor WAY M 1 WAY M M 1 WAY M M 1 WAY M M M M M M M M M M M M M M M M M M M	COPATION OF THE PROPERTY AT DRK? YES 2 NO	TAIN E	i. 24a. WAS AN PERFOR 1 YES 2 Other (Specify) DESCRIBE HOW I City or Town, State)	AUTOPSY IMPED?	2 4b CURED or Bural F	Interval Batween Onset and Death (MovTel (7 YeArs) WERE AUTOPSY FINDINGS AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
COMPLETED BY PHYSICIAN: MEDICAL	shock, or heert failure. Lie iMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST PART II. Other eignificant conditions of the condi	DUE TO (OR AS A CONTINUED TO (OR AS A CONTIN	SEOUENCE OF DEAT 128b. TIME INJ. death occurrence of the communication	CP SLA- P: CRC I P: CRC I	COPATION OF THE PROPERTY AT DRK? YES 2 NO	TAIN E	i. 24a. WAS AN PERFOR 1 YES 2 Other (Specify) DESCRIBE HOW I City or Town, State)	AUTOPSY MED? NO NJURY OCC and Number nner as stated due to the	24b CURED or Rural F ed. ee cause(s	Interval Batween Onset and Death (MovTel (7 YeArs) WERE AUTOPSY FINDINGS AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BE COMPLETED BY PHYSICIAN: MEDICAL	shock, or heert failure. Lie iMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST PART II. Other eignificent conditions of the condi	DUE TO (OR AS A CONTENT OF THE PROPERTY OF THE	SEQUENCE OF DEAT 1 DOA 28b. TIM INJ	The underlying the un	LOPATION OF THE PROPERTY OF TH	TAIN E	i. 24a. WAS AN PERFOR 1 YES 2 Other (Specify) DESCRIBE HOW I City or Town, State)	AUTOPSY MED? NO NJURY OCC and Number nner as stated due to the	24b CURED or Rural F ed. ee cause(s	Interval Batween Onset and Death (Month! (7 General Content of Cause of Death? 1 Yes 2 No Route Number,
COMPLETED BY PHYSICIAN: MEDICAL	Shock, or heer failure. List iMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST PART II. Other eignificent conditions of the condi	DUE TO (OR AS A CONTENT OF THE PROPERTY OF THE	SEQUENCE OF SEQUEN	In the underlying the control of the time, defined at the time, defined, in my opinion, of the control of the c	COPATION OF THE PROPERTY OF TH	TAIN E	i. 24a. WAS AN PERFOR 1 YES 2 Other (Specify) DESCRIBE HOW I LOCATION (Street City or Town, State)	AUTOPSY MED? NO NJURY OCC and Number nner as stated due to the	24b CURED or Rural F ed. ee cause(s	Interval Batween Onset and Death (Month! (7 General Content of Cause of Death? 1 Yes 2 No Route Number,



ges 1, 2, 3 should

1	-	FOR STATE REGISTRA	F
1	1. D	ECEDENT'S N	A

	REGISTRAR		CE	RTIFIC	ATE OF	DEATH	1	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF MONTH	DEATH	NY .	YEAR	3. TIME OF DEATH
		Bertha Mar					2	5	_	95	12.55 PH
	S. 2 S. M. S. S.		E (In yrs. last	MOI	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF (Month, D			8. BIRTH Countr	PLACE (State or Foreign
	130 - 03 - 0023		80	YRS.		I IIII	July	12,19	914	Nev	Jersey
~	9a. FACILITY NAME (If not institution, give stre			96	CITY, TOWN	OR LOCATION OF D	EATH		9c. COU	NTY OF D	EATH
DIRECTOR	Laurel Regional Ho	spital		I	aurel				Pri	nce (George
<u>n</u>	10a. STATE 10b. COUNTY	· · · · · · · · · · · · · · · · · · ·		10c. CITY, TO	OWN OR LOCA	TION					10d, INSIDE CITY
뜸	Maryland Howard	3		Colum	bia						LIMITS?
	10e. STREET AND NUMBER					f. ZIP CODE			10g. CIT	IZEN OF W	/HAT COUNTRY?
FUNERAL	5764 Stevens Forre	est Road				21045			US	A	No.
5		12. WAS DECEDENT EVER				CENDENT OF HISPA			or No-	14. RACE	American Indian,
BY F	1 Never Married 2 X Married 3 Widowed 4 Divorced	FORCES? 1 TYE)		pecify Cuban, Mexic S 2 P NO Speci		n, etc.)		Speci	, White, etc. ly:
					<u> </u>	A.					White
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of		16a. OEC	EDENT'S USU kind of work	IAL OCCUPATI done during m lired.)	ON ost of working	16b, Kil	ND OF BUS	INESS/ING	DUSTRY	
1 1	Elementary/Secondary (0-12)	College (1-4 or 5+) Year		cher	erea.)		Cal	1	C		
M	17. FATHER'S NAME (First, Middle, Last)	. Ieal	read	cher		18. MOTHER'S N		nool		em	
	Raymond McPeek					Viola V		lle, Melden	Surname)		
BE	19a. INFORMANT'S NAME (Type/Print)		19b.	MAILING ADD	ORESS (Street	and Number or Rural		City or Town	n State 7ie	n Codel	
2	William E. Ayres					Forrest					21045
1	20a. METHOD OF DISPOSITION 1 General Burlai 2 Cremation 3 Remov	2			SPOSITION (N		DATE	_		City or To	
	1 ☐ Buriel 2 ☑ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	ral from State	Metro	etory or other p	tory,	Inc.	2/8				, Maryland
ı	21. SIGNATURE OF FUNERAL SERVICE LICE				22. NAME A	ND ADDRESS OF F	ACILITY				7.00.7
	+ (Tens	L -				ldson Fu					3 00000
	23. PART I. Enter the diseeses, or co	molications that cause	and the dear	th. Do not a	313 '	Calbott A	Ave. La	urel	, Ma	ryla	
	anock, or heart feiture. Li	at only one cause on	each iine.	iii. Do not i	sinter the m	or aying, sa	un as cerulac	or respii	ratory an	reet,	Approximate Interval Between
	iMMEDIATE CAUSE (Final disease or condition	Sehr	21								Onset and Death
ļ	resulting in death)	DUE TO (OR AS	4-CONSEQU	JENCE OF:							
z		1	Prem	one	e,						i
은	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS	A CONSEQU	ENCE OF):							
2	CAUSE (Disease or injury										
# 1	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQU	JENCE OF):							
CERTIFICATION	d.										
	PART ii. Other aignificant conditions	contributing to death	but not rea	aulting in th	ne underiyin	g ceuse given in	Part I. 24	. WAS AN		24b.	WERE AUTOPSY FINDINGS
MEDICAL								PERFOR			AWAILABLE PRIOR TO COMPLETION OF CAUSE
Ä			-				`		ZZIVO		DF DEATH? 1 YES 2 NO
ä	DID TOBACCO USE CONTRI	BUTE TO CAUSE	OF DEAT	H YES	□ NO [UNCERTAL	N D				
<u>₹</u>	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE	OF DEATH (C	heck only one						
SK	. The second of the	HOSPITAL:	utpatient 3		HER: Nursing Hor	ne 5 🗆 Residence	6 Other (S	pecify)			
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF INJUR (Month, Day, Year	Y	28b. TIME OF		JURY AT	28d. DESCRI	BE HOW IN	JURY OC	CURED	
BY	1 Natural 5 Pending 2 Accident Investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	·	moon		YES 2 NO					
	3 Suicide 8 Could not be	28a. PLACE OF INJUI building, atc. (Sp	RY — At hom- pecify)	e, ferm, atree	t, factory, offic	20	281. LOCATIO	N (Street as	nd Number	or Rural R	oute Number,
	4 Homicide determined										
COMPLETED	(Check only 1 CERTIFYING PHYSICI.										
Š	one) 2 MEOICAL EXAMINER:	On the trades of examinat	tion and/or Im	reatigation, in	my opinion,	leath occured at the	time, data and	place, and	dua to th	ne cause(a)	and menner as stated.
BE	296. SIGNATURE AND TITLE OF CENTIFIER	When	MMD			29c. LICENSE NU					(Month, Day, Year)
TO B		01	YPID	C.		72428				.5.	
	30. NAME AND ADDRESS OF PERSON WHO M. YUSUF MD	3450 A	SEATH (ITEM	27) (Type, Prin	"de	Road	Lan	rol	MJ	20	707
	31. DATE FILED (MONTH) Day, Year)	32. HEGHETHAR'S SIG	SNATURE Lacker	Sall		· <u>-</u>					



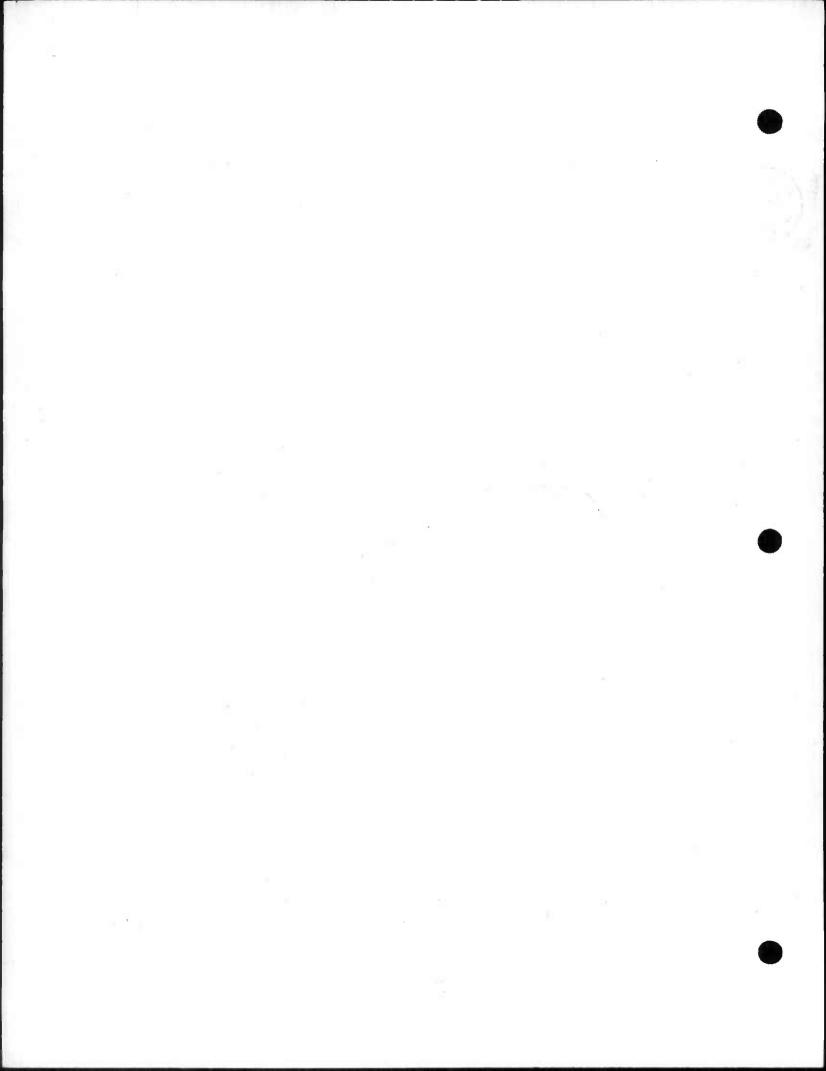
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burne-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

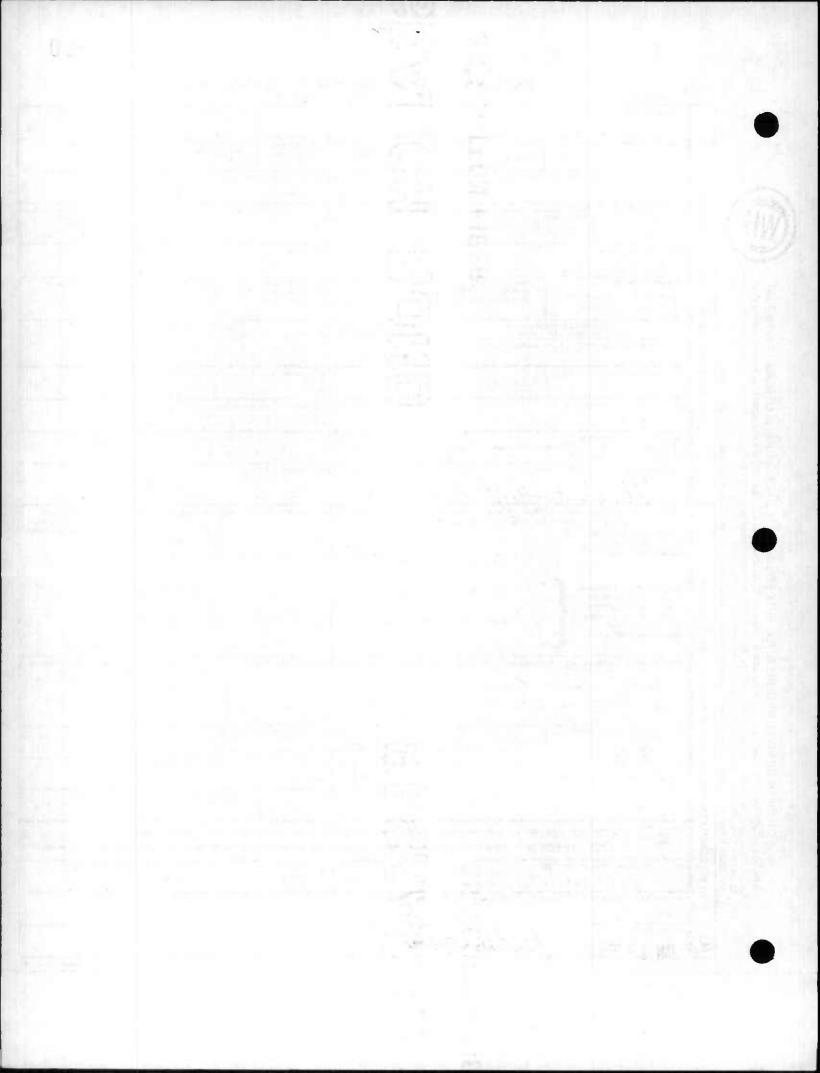
1 - STATE

-	REGISTRAN			Eniir	IVALL	- 01	DLA		H	EG. NO.			
- 9	1. DECEDENT'S NAME (First, Middle, La	st)							2. DATE OF D	EATH DAY		YEAR	3. TIME OF DEATH
- 3		Alex	W. Alex	is					Febru				7:00 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. I	est birthday)	IF UNDER		IF UNDER		7. DATE OF B	HTTH		8. BIRTH	IPLACE (State or Foreign
	189-05-9902	1 🔀 M 2 🗌 F	88	YRS.	MONTHS	DAYS	HOURS	Mm.	(Month, De)	,	906	Count	m nsylvania
	99. FACILITY NAME (If not institution, gi				9b. CITY,	TOWN	R LOCATIO	ON OF DE		7		INTY OF D	
DIRECTOR	Shady Grove Adv					Rock	vill	e			Mo	ntgo	merv
5	RESIDENCE OF BECEDENT											0 9 0	
2				7.5	Y, TOWN O		ION						10d. INSIDE CITY LIMITS?
		erne			ings	con							1 YES 2 NO
₹	10e. STREET AND NUMBER					101	. ZIP CODE				10g. CIT	IZEN OF V	WHAT COUNTRY?
9	109 Division						18	704			Uni	ted	States
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDEN	T EVER IN U.S. A	RMED	13. \	MAS DEC	ENDENT O	F HISPAN	IIC ORIGIN? (Sp n, Puerto Rican	ecify Yes	or No-	14. RACE	— American Indian, t, White, etc.
BY	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE Y	MAR OR DATES	,			2 🙀 NO			, 414.7		Speci	fy:
	15. DECEDENT'S E	DUCATION	40.10	FOFOFILTIO									White
COMPLETED	(Specify only highest gi	ade completed)		Give kind of vie. Do NOT us	vork done o	during mo	on st of working	g	16b. KINI	OF BUS	INESS/IN	DUSTRY	
2	Elementary/Secondary (0-12)	College (1-4 or 5	+)	oal M					Co	al M	ines		
<u></u>	17. FATHER'S NAME (First, Middle, Last)						C						
	William Alexis								ME (First, Middle				
BE	19e. INFORMANT'S NAME (Type/Print)		1	OF MAILING	ADDRESS	(0)			eth Ne Route Number, Ca				
5	Rosemary Chisari	ck							ckvill				20050
	20e. METHOD OF DISPOSITION	- CA			_	_							
	1 Surial 2 Cremation 3 R	emoval from State	Cernetery, C	rematory or of	ner piace)				7			City or To	wn, State Wp., PA
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	- I Holy	Trin			tery D ADDRES			bear	Cre	ek T	wp., PA
	Rauf	touch	MOO	198	R	ober	t A. West	Pum	phrey	Fune y Av	ral enue	Home	/Rockville,
	23. PART I, Enter the diseases,	or complications the	t caused the d	leeth. Do n	ot enter	the mo	de of dyle	e, M	arylan	or reapin	0850 atory ar	-280 reet,	5. Approximate
	shock, or heart fallu- IMMEDIATE CAUSE (Finel	e. List only one cer	use on each lin	e.									interval Between Onset and Death
	disease or condition	0	NEUMO	AHA									
	resulting in death)		(OR AS A CONSI										FEW DAYS
z		· CHR	PIC C	2BCT	RUCI	TIVE	P	LM	ONARY	DI	SEF	TSE.	SEVERAL
	Sequentielly list conditions, if eny, leading to immediate	DUE TO	(OR AS A CONSI	OUENCE OF	7:					100	,		YEARS
2	cause. Enter UNDERLYING CAUSE (Disease or Injury	C											
E	that initiated events	DUE TO	(OR AS A CONSE	OUENCE OF	7:								
H	resulting in death) LAST	d											
EDICAL CERTIFICATION	PART ii. Other algnificant condit	one contributing to	death but not	resulting I	n the un	deriving	COURA O	luen in i	Port I na	WAS AN A	umanav	100	WERE AUTOPSY FINDINGS
S	ANTHRASIL				., .,,	ao ay mg	, couse y	10011 1111	Fait 1. 248.	PERFORM		240.	AMAILABLE PRIOR TO COMPLETION DF CAUSE
									- 10	YES 2	NO		OF DEATH?
Σ	DID TORACCO LISE CON	ITDIDLITE TO CA	USE OF DE	ATIL VE		10 [1 115100	EDTA IN					1 TYES 2 NO
PHYSICIAN:	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CA		CE OF DEAT			UNC	CKIAIN	NE				
[[]	EXAMINER?	HOSPITAL:			OTHER	:			1				
Ĕ∥	27. MANNER OF DEATH	28e, DATE OF		28b, TIM		28c. INJ		sidence	8 Other (Spe 28d. DESCRIB		HIBY OC	CLIBED	
	th Natural 5 ☐ Pending	(Month, D	lay, Year)	INJ		WO		NO.	ZOG. DESCHIE	L HOW IN	30117 00	CONED	
B	2 Accident Investigation 3 Suicide & Could not	28e PLACE O	F INJURY — At h	ome, ferm, s	treet, facto			-	28f. LOCATION	(Street on	od Number	or Burni B	inute Musebas
	4 Homicide 6 Could not determined	building,	etc. (Specify)			,,			City or Tow	n, Stete)	is riginos	O FISHER F	oute Manipus,
۳ ا	29e. CERTIFIER	COLCIA N. To the best of									-	_	
COMPLETE		YSICIAN: To the best of NER: On the basis of a											200,000,000,000,000
8			American Brick/Of	veetigatio	ii, iii my of	amon, de	with occure	ra at the	nme, date and p	place, and	due 10 th	te cause(e)	end manner as stated.
H H	296. SIGNATURE AND TITLE OF CERTIF	era M.	0				29c. LICE				-		(Month, Day, Year)
2		*					D	36	532		PFG	BRU	ARY 2 1995
	P. TALWAR, 5	OW GOI				#	401	. 6	OCKV	ILLE	< ~	10. 2	20852
	FEB US 1995	July a Dancy	R'S SIGNATURE	-									



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020	ORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Jours after death. Page 6 may be retained by the hospital or attending physician.	6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit in mill. Presented within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, or removal.	ector, page 5 should be detached for use as the burial-transit promit.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	must be notified at once.

1 -	FOR STATE REGISTRAR	STATE OF MARYLAI	ND / DEPARTM			MENTAL HYGIEN		
1. 0	DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF DEATN		3. TIME OF DEATN
1	Helen M. Burcha	rd				Jan. 7.	1995 YEA	3:15 P M
				UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)	8. B	IRTHPLACE (State or Foreign ountry)
	218-20-4442A 1	□ M X□ F 91	YRS.	VTHS DAYS	HOURS MIN.	June 18		
- 1	FACILITY NAME (If not institution, give street	and number)	9b	CITY, TOWN	R LOCATION OF D	EATN	9c. COUNTY (OF DEATH
DIRECTOR 10-01	Magnolia Hall	564		Chest	ertown		Ken	t
10s	ESIDENCE OF DECEDENT 1. STATE 10b. COUNTY		10c, CITY, TO	OWN OR LOCAT	ION			10d, INSIDE CITY
E I	Maryland Queen	Anne's	Ch	nurch	HIll			LIMITS?
	. STREET AND NUMBER		100 100-000	101	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	General Deliver	У			21623		U.S	. A .
N 11.		WAS DECEDENT EVER IN U	U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No. 14. F	RACE — American Indian, Black, White, etc.
- 11 ×	Never Married 2 Married Wildowed 4 Divorced	FORCES? 1 YES	ES NO		2 NO Specif	en, Puerto Rican, etc.) ly:		Panelle:
								White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade com	DN 1 pleted)	(Give kind of work life. Do NOT use re	done during mo	N at of working	16b. KIND OF BU		
١٣	Elementary/Secondary (0-12)	ollege (1-4 or 5+)			3.73	Nursin	ng Hom	е
N 17	FATHER'S NAME (First, Middle, Lest)		Nurse	's Ai		AME (First, Middle, Maiden	Sumama)	
	John Hodson Bur	ahard						
100	. INFORMANT'S NAME (Type/Print)	Спати	19b. MAILING AD	DRESS (Street a		e Ann Wic		9)
2 1	Mrs. Reba Smith					ch Hill,		
	. METHOD OF DISPOSITION		PLACE AND DATE OF D		me of	DATE 20c. LO	CATION - City of	or Town, Stata
	Rurial 2 Cremation 3 Removal Donation 8 Other (Specify)		ery, crematory or other	place)	Jan	.10,1995	hurch	Hill, Md.
21.	SIGNATURE OF FUNERAL SERVICE LICENS	EE / /		22. NAME A	ID ADDRESS OF FA	CILITY		
	1 // may Ka	11.01.0	5	TOM 555 N	Hellen	bein Fune	eral H	omes, PA
23	I. PART I. Enter the diseases, or com	olications that caused t	the deeth. Do not					Approximata
IFICATION IN SECULAR SECURAR S	sease or condition sulting in death) a aquantially list conditions, any, leading to immediate luse. Enter UNDERLYING AUSE (Disease or injury at initiated events auiting in death) LAST d	DUE TO (OR AS A C	CONSEQUENCE OF):	untre	F			
	ART II. Other significant conditions of	ontributing to death but	not resulting in t	he underlyin	cause given in	Part I. 24a, WAS AN	ALITOPRY	24b. WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL		4: 11		ese	, cacco given in	PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
	D Character	0	Dail .			1 TYES 2	MO	OF DEATH?
Σ	(2) discourse 1	and the	1001	/	01	_		1 TES 2 NO
Z	WAS CASE REFERRED TO MEDICAL	cornany	no mo	26 P	ACE OF DEATH (C)	eck only one)		
[]		OSPITAL:	lant 3 DOA of	THER:		6 Other (Specify)		
¥ 27.	MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME O	F 28c. IN.	URY AT	28d. DESCRIBE HOW	NJURY OCCURE	D
_	1 Natural 5 Pending	(Month, Day, Year)	INJURY	M 1	RK? 'ES 2 NO			
	3 Suicide 6 Could not be	26s. PLACE OF INJURY - building, etc. (Specify	- At home, farm, stree	rt, factory, offic		281, LOCATION (Street		ural Route Number,
	4 Homicide determined	Continuity of the (opensy)	'			City or Town, State;		
296	CERTIFIER 1 CERTIFYING PHYSICIAN	: To the best of my knowled	dge, death occurred a	t the time, date	and place, and due	to the cause(s) and ma	nner se stated,	
COMPLETED	one) 2 MEDICAL EXAMINER: 0							use(a) and manner as stated.
	SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU	MBER	29d. DATE SIG	NED (Month, Day, Year)
H 296	1661 When	, mo			D213			an. 9, 1995
P 30.	NAME AND ADDRESS OF PERSON WHO CO		TH (ITEM 27) (Type, Pri	nt)			00	111, 9, 1793
	Kin K. Wun, M.I	216	High St	reet.	Cheste	ertown, M	d. 216	520
	DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	TURE		2.1.3000		~ 210	20
4	IAN 12 '05 4u	lia Davidson-Ra	ndelle					



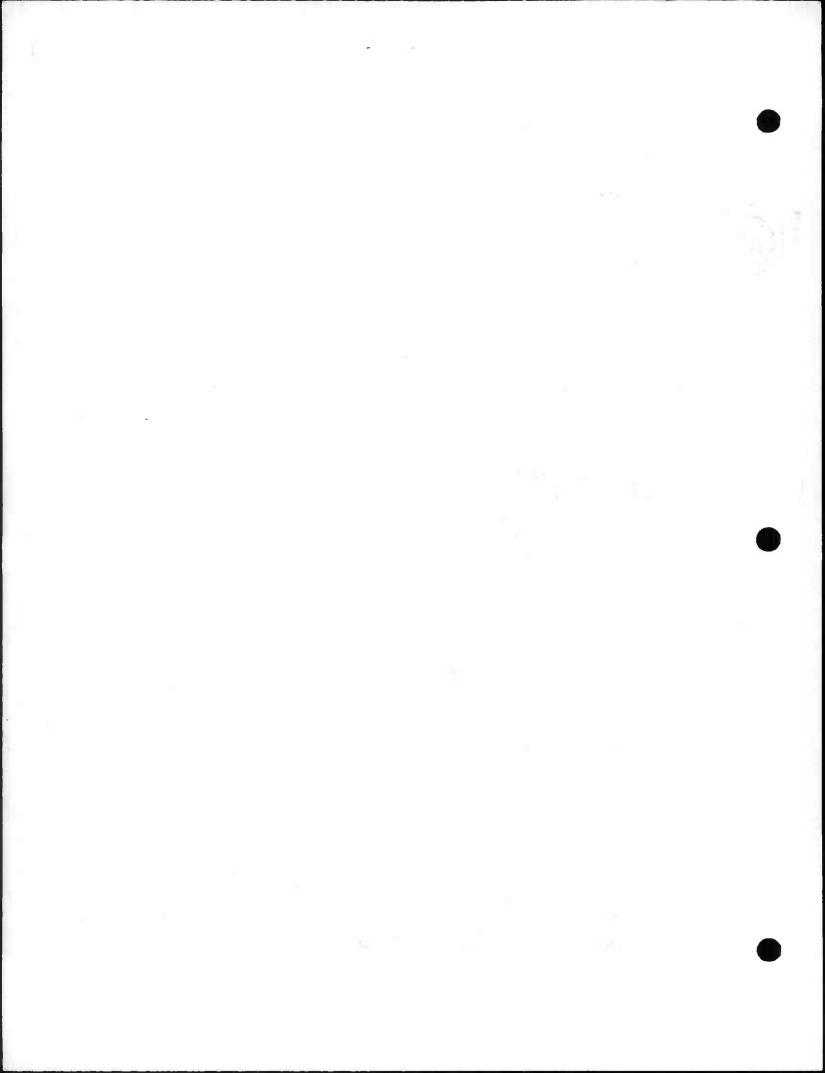
BALTIMORE, MARYLAND 21215-0020 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burns be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. hours after death. Page 6 may be retained by the hospital or attending physic TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR	_	CERTIFIC	CATE OF	DEATH	REG	NO.			
	1. OECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEA			3. TIME OF DEATH	
	Mildred Elizabeth	Brooner				January	fo, 19	9 g Z **	0105	Ан
1			yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT	Н	8. BIRTH	IPLACE (State or Foreign	_
1 8	011-16-1516	□ M 2 🟋 79	YRS.	ONTHS DAYS	HOURS MIN.	May 2	9^{-1} . 1915	Countr Kai	nsas	
	9a. FACILITY NAME (If not institution, give stree	et and number)	9	b. CITY, TOWN O	R LOCATION OF DE			NTY OF D		-
E I	Kent & Oueen Annel	s Co Hospit	al Inc	Che	estertow	n	1	KEnt		
5	Kent & Queen Anne'	3 00: 1103p10	ar me	0110	-3 CCT COWI	1		\LII U		
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION				10d. INSIDE CITY LIMITS?	
	Maryland Kent		Che	sterto	own_				1 NYES 2 NO	
ĭ.	10e. STREET AND NUMBER			100	ZIP CODE		10g. CIT	IZEN OF V	VHAT COUNTRY?	
ij	101 Birch Run Ro	<u>sad</u>		2	21620		US	A		
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married	2. WAS DECEDENT EVER IN U FORCES? 1 YES	S.ARMED	13. WAS OEC	ENDENT OF HISPAN	IIC ORIGIN? (Speci	fy Yas or No-	14. RACE	E — American Indian, c, White, alc.	
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATE			2X NO Specify		<i>⊷</i>)	Speci	fy:	
ED				1					nite	
	15. DECEDENT'S EDUCAT (Specify only highest grade cor	mpleted)	8a. DECEDENT'S US (Give kind of wor	SUAL OCCUPATION rk done during mostretired.)	N st of working	16b. KIND O	F BUSINESS/IN	DUSTRY		
2	Elementary/Secondary (0-12)	College (1-4 or 5 +)								
COMPLET	17. FATHER'S NAME (First, Middle, Last)	6	Civic	Worker						_
	Lowell A. Crane					ME (First, Middle, M				
띪	19a. INFORMANT'S NAME (Type/Print)	<u>- </u>	40h MAILING A	DD0500 (0)	nd Number or Rurel I	I. Stu				
임	George M. Broone	ΣΥ							0.21620	
	20a. METHOD OF DISPOSITION		LACE AND DATE OF				c. LOCATION —			\dashv
	1 Burial 2 Cremation 3 Ramova 4 Donalion 5 Other (Specify)	If from State comete	ary, cremetory or othe	r plece)						
	21. SIGNATURE OF FUNERAL SERVICE LICEN	Ime t	tro cre	matory	D ADDRESS OF FA	1-10	Balto		4D	\dashv
	7-20	3/1/					Home	130	Sneer	- 1
	Aux .	Sugar.	en	Road	Cheste	rtown,	MD. 2	1620) Speer	
	23. PART ILEnter the diseases, or com shock, or heart failure. Lis	nplication that caused to it only age cause on eac	ha death. Do not h line.	enter the mo	da of dying, auci	h aa cardlac or	reapiratory ar	rest,	Approximate Interval Batwe	
	IMMEDIATE CAUSE (Final	07		- /	1				Onset and De	
	disease or condition resulting in death) a	/V VOCO	+ dim	Int	archuo)			112 hr	5.
		DIE TO (OR AS A C	ONSEQUENCE OF):							
N	Sequentially list conditions, b.									
Ĕ	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A C	ONSEQUENCE OF):							
일	CAUSE (Disease or Injury	DUE TO (DR AS A CI	ONCEONENCE OF							
Ē	that initiated eventa resulting in death) LAST	00L 10 (011 NO N 01	ONSEGUENCE OF J.						İ	- 1
CERTIFICATION	d								<u> </u>	
A	PART ii. Other significant conditions of			tha undariying	cause given in	Part I. 24s. W	AS AN AUTOPSY	24b.	WERE AUTOPSY FINDIN	vGS
DICAL	It / 2 hermer	-s W/S	ease			1	ES 2 NO		COMPLETION OF CAUSE OF DEATH?	E
ME									1 YES 2 NO	- 1
ž	DID TOBACCO USE CONTRIB	BUTE TO CAUSE OF	DEATH YES		UNCERTAIN	1 D				
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28. (OSPITAL:	PLACE OF DEATH							
S	1 TES 2 NO			OTHER:	5 Rasidence	8 Other (Specify)			
PHYSICIAN:	27. MANNER OF BEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (OF 28c. INJU		28d. DESCRIBE H	IOW INJURY OC	CURED		
BY	1 Natural 5 Pending 2 Accident Investigation				ES 2 NO					
8	3 Suicide 8 Could not be	28a. PLACE OF INJURY — building, atc. (Specify)	At home, farm, stre	et, factory, office	_	28f. LOCATION (S City or Town,	treet and Number	or Rural A	loute Number,	
	4 Homicide determined									
COMPLET	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIA	N: To the best of my knowled	ge, death occurred	at the time, data	and place, and due	to the cause(e) an	d manner as sta	ted.		
8		On the basie of examination e) and manner as stated	
	296. SIGNATURE AND TITLE OF CERTIFIER	/			29c. LICENSE NUN	IBER	29d. DAT	E SIGNED	Oloren, Deal Years	-1
BE	6110 (1	Promo Mann.	- M Y	, [0/1/20	198	> /	/	10/95	- [
유	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEATH	1 (ITEM 27) (Type, Pr	rint)			, ,	1	16	\dashv
	Wayne D.	Benia	min	Mo	DC	Lect	ento	WA	NX	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATI		7	7	1100	. 11.	- //	170	\dashv
	MN 12 '95	Luka Day	idner-Rand	.00						



BALTIMORE, MARYLAND 21215-0020 ours after death. Page 6 may be retained by the hospital or attending physici

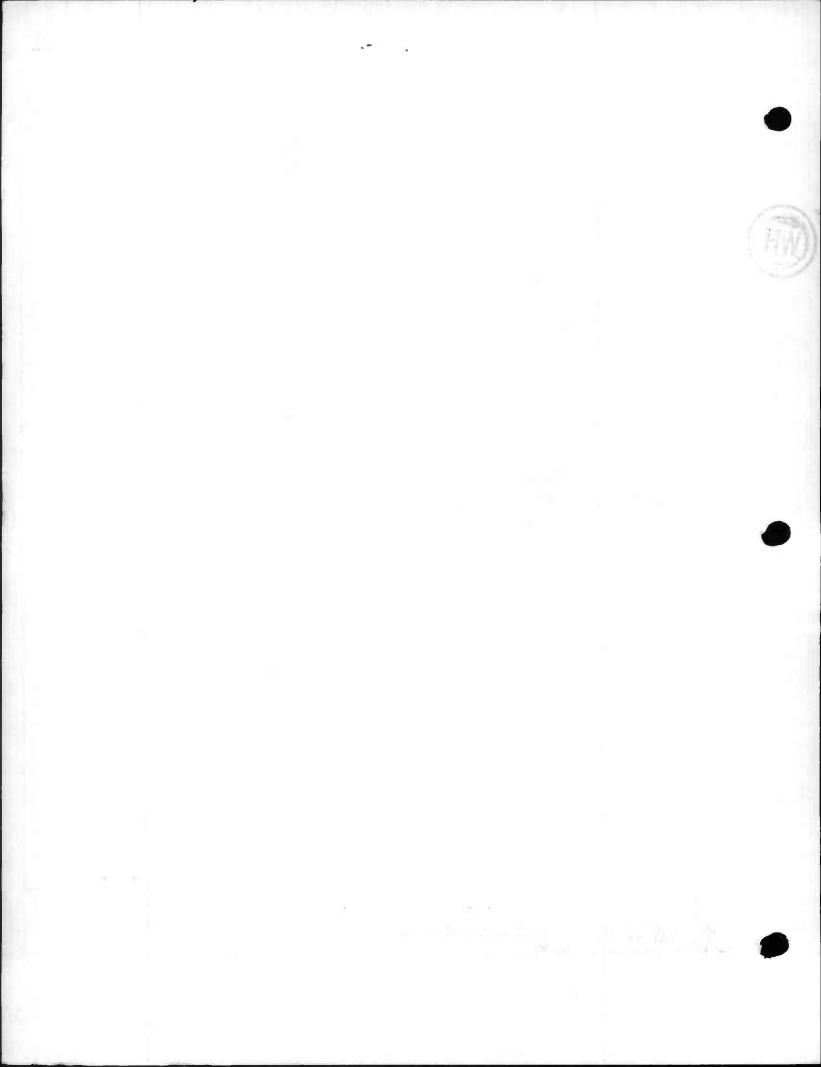
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

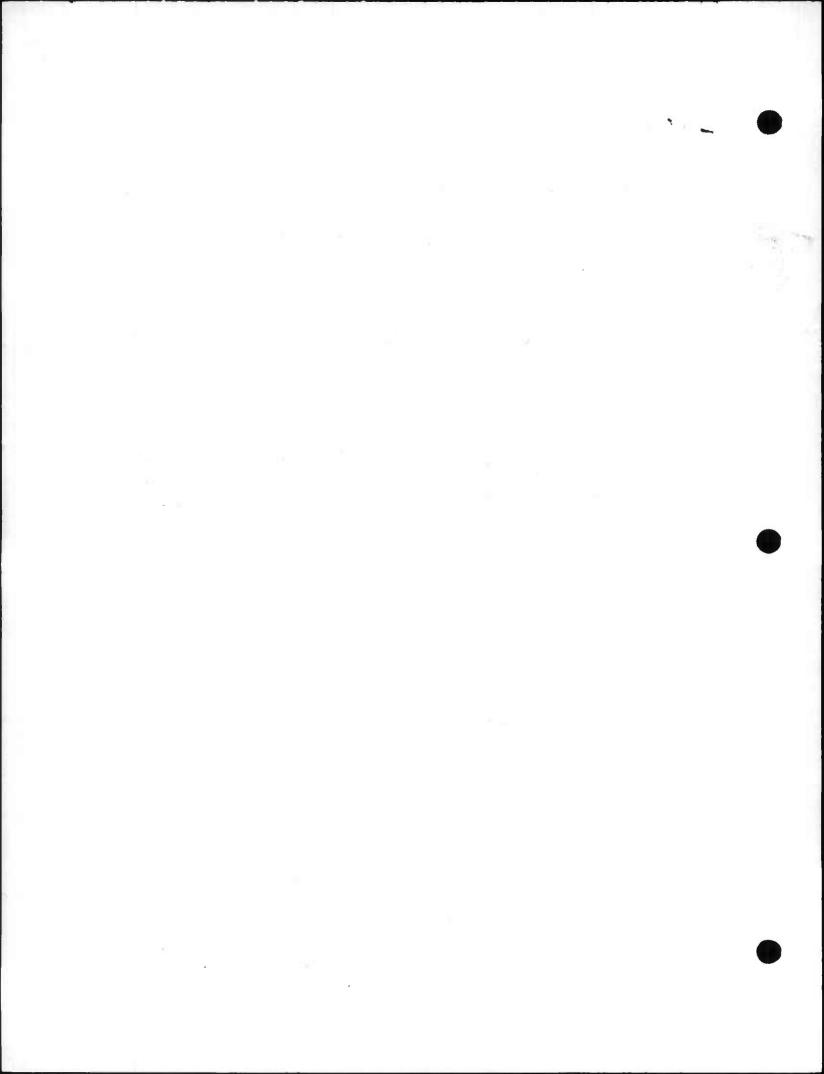
11, 2, 3 should

1 - STATE OF MARYLA REGISTRAR	ND / DEPARTMENT OF HI CERTIFICATE OF		AL HYGIENE REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) Bertha Blanch		2. DA	TE OF DEATH	YEAR	TIME OF DEATH 2110 hrs M
4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In $221-46-4711$ $1 \square \text{ M } 2 \ \text{X} \text{ F}$ 7.5	yrs. last birthday) IF UNDER 1 YEAR	IF UNDER 24 HRS. 7. DA'	TE OF BIRTH porth, Day, Year) cember 1, 1919	8. BIRTHPL Country)	ACE (State or Foreign
96. FACILITY NAME (If not institution, give street and number) Laurelwood Nursing Home RESIDENCE OF DECEDENT		LOCATION OF DEATH	9c. CO	Ceci.	
Delaware Kent	10c. CITY, TOWN OR LOCATE	Layton			Od. INSIDE CITY LIMITS? YES 2 X NO
Rd 2 Box 362		19938	Ur		States
11. MARITAL STATUS 1 Never Married 2 Merried 3XXWIdowed 4 Divorced 12. WAS DECEDENT EVER IN 1 FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO It yes, spec	NDENT OF HISPANIC ORI Ify Cuben, Mexican, Puer NO Specify:	GIN7 (Specify Yea or No— to Rican, etc.)	Black, Specify:	- American Indian, White, etc.
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	ISA. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) Homemaker		Domest	DUSTRY	
17. FATHER'S NAME (First, Middle, Last) Frank McGinnis	TYNIKINGL	18. MOTHER'S NAME (First	it, Middle, Maiden Surname)		
19a. INFORMANT'S NAME (Type/Print) Frank McGinnis	19b. MAILING ADDRESS (Street en Rd 2 Box 363	Number or Rural Route No	umber, City or Town, State, Z.	19938	
1 Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	PLACE AND DATE OF DISPOSITION (Namery, creshitory or other place) Line tery - J	anuary 18,	1995 Barc	lay, M	iaryland
William L. Kips Jr.			Homes, P.A. Millington, M		
23. PART I. Enter the diseases, or complications that caused to shock, or heart fellure. List only one cause on each immediate CAUSE (Final disease or condition resulting in death) Rehal Fa	ilure		erdiac or respiretory as	reat,	Approximate interval Between Onset and Death three y
Sequentially list conditions b.	mellitus typ	e 1			20 yrs
if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST					
PART II. Other algoriticant conditions contributing to death but Ischemic cardiomyopath	not resulting in the underlying y, Poss Ca of	ceuse given in Part I. Uterus	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	A C	ERE AUTOPSY FINDINGS MALABLE PRIOR TO DMPLETION OF CAUSE F DEATH? YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpatient 2 ER/Outpet	OTHER:	CE OF DEATH (Check only			
27. MANNER OF DEATH 1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation	28b. TIME OF 28c. INJU INJURY WOR	5 Residence 8 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ther (Specify) DESCRIBE HOW INJURY OF	CCURED	
	At home, term, street, tectory, office	281. Lt	OCATION (Street and Number lty or Town, State)	or or Runal Rou	te Number,
9e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowled one)					nd menner se stated.
96. SIGNATURE AND TITLE OF CERTIFIER WELLA DE DE MANUEL 10. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEAT	MD	esc. Ligense number 9	29d. DAI	TE SIGNED (M	lonth, Day, Year) • 95
Wallace Obenshain, M.D. C	ecilton, Md. 2	1913			



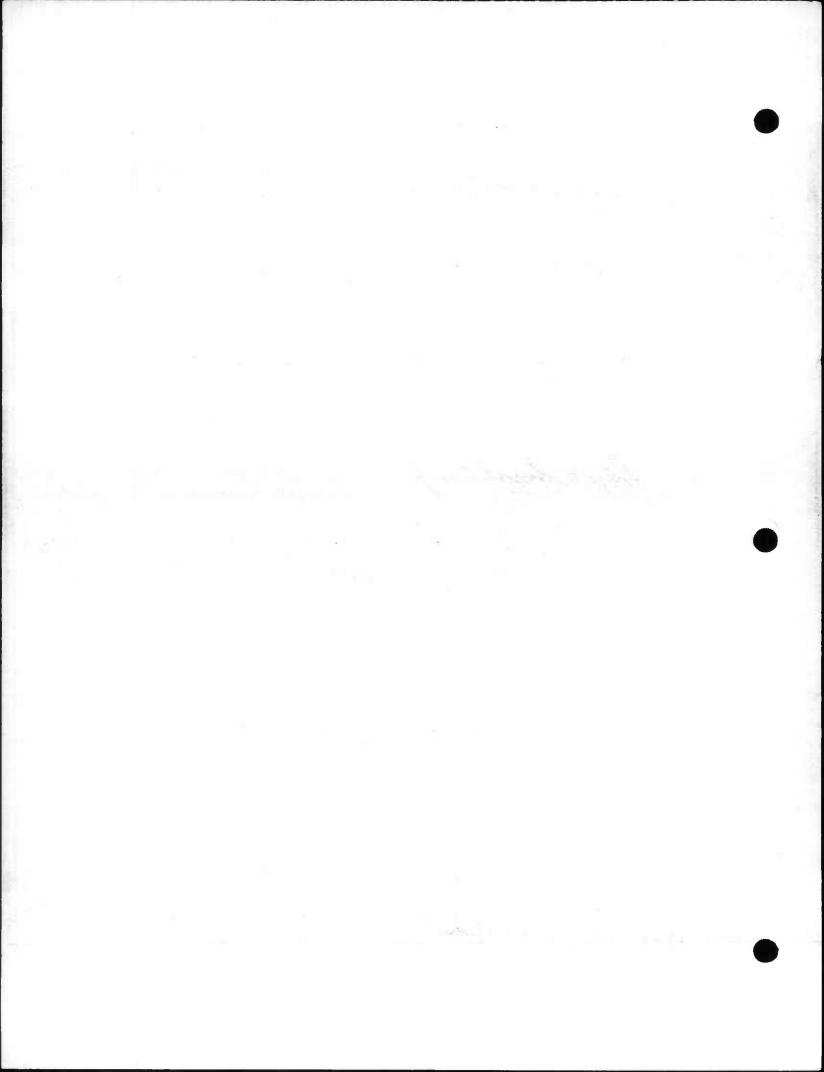
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fter c	the
CQ .	5
OUL	i.
2	fille
IDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death,	. After this certificate has been signed by the attending physician and completely filled in by the funera
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ficate	physi
certi	guipi
death	atter
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Jat	4
ires th	: After this certificate has been signed by the attending physic
requ	Deed :
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AN:	ifica
SICI	cert
PHY	this
ING	After
9	-

	1 - FOR STATE REGISTRAR	STATE OF MARYL		ENT OF HEAL		ENTAL HYGIEN		
- 1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	Mary	Elizabeth	F	Butler	I	anuary 26		11:53A M
	4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	UNDER 1 YEAR IF UN		7. DATE OF BIRTH	8, BII	RTHPLACE (State or Foreign
	217-34-6029	1 - M 2 F 6	9 YRS. MO	NTHS DAYS HOUR		(Month, Day, Year) MAY 3, 19		(ARYLAND
- 1	9a. FACILITY NAME (If not institution, give s			CITY, TOWN OR LOC			9c. COUNTY O	
DIRECTOR	Physicians Memo	rial Hospita	1 1	a Plata			Charles	
E I	toe. STATE 10b. COUNT	Υ	10c. CITY, TO	OWN OR LOCATION				10d. INSIDE CITY
	MARYLAND CHAR	LES	MARSH	ALLS CORN				1 YES 2XXNO
FUNERAL	ROSE HILL ROAD				1646			F WHAT COUNTRY?
3	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED			ORIGIN? (Specify Yee		STATES ACE — American Indian.
	1 X Never Merried 2 Married	FORCES? 1 YES		If yea, specify C	uban, Mexican, I	Puerto Ricen, etc.)	В	lack, White, etc.
BY	3 Widowed 4 Divorced			1 123 242	во врешу.		3	BLACK
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION COMPLETE	16a. DECEDENT'S USU	JAL OCCUPATION done during most of we	nekina.	166. KIND OF BUS	INESS/INDUSTR	
91	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use re	tired.)	orang			
P	11TH GRADE		HOUSE C	LEANER		PRIVA	TE	
8	17. FATHER'S NAME (First, Middle, Last)			18. M	OTHER'S NAME	(First, Middle, Maiden	Surname)	
BE	CLARENCE BUTLER			LO	UISE DY	YER BUTLE	R	
10	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING ADI	DRESS (Street and Num	nber or Rural Rou	ite Number, City or Town	, State, Zip Code)	
-	SHIRLEY WILLIAMS		ROUTE #	2 BOX #20	82 LA 1	PLATA, MA	RYLAND	20646
	20e. METHOD OF DISPOSITION XXX Burlet 2 Cremetion 3 Rem	ioval from State C81	b. PLACE AND DATE OF D	place)	Company of the Compan		CATION - Cify or	Town, State
	4 Donation 5 Other (Specify)	S	T. JOSEPH				FRET. M	ARYLAND
	21. SIGHAPURE OF FUNERAL SERVICE LI	firster Joh	nson	22. NAME AND ADD	FINER	AL HOME,	РΔ	
	LYDIA C. THORN	TON JOHNSON					20640	
	23. PART I. Enter the diseases, Dr	complications that ceuee List pnly one ceuse on e	ed the deeth, Dp not				ratory arrest,	Approximata
	IMMEDIATE CAUSE (Final	1			111	2 1	()	interval Between Onset and Death
ľ	disease or condition	MINTER	scare	when	~ 1	Cuy by	1 1	15
	resulting in death)		01000	-	11 22		1 1000	7
	resulting in death)		A CONSEQUENCE OF			0	1 (10	7
NO	Sequentially list conditions,	DUE TO (OR AS	A CONSEQUENCE OF	Low	n Vija	cond	nae	,)
ATION		DUE TO (OR AS		Low	10	cand	nac	,)
FICATION	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury	b. DUE TO (OR AS. DUE TO (OR AS. C. OVER	A CONSEQUENCE OF	mel	10	Card Khis c	nae	
RTIFICATION	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING	b. DUE TO (OR AS. DUE TO (OR AS. C. OVER	A CONSEQUENCE OF):	Mon	10	Card Krisc	nae	
CERTIFICATION	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted evente resulting in deeth) LAST	b. DUE TO (OR AS. DUE TO (OR AS. DUE TO (OR AS. d.	A CONSEQUENCE OF): A CONSEQUENCE OF):	melan	7/9	Card Khis c	nae	
	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evente	b. DUE TO (OR AS. DUE TO (OR AS. DUE TO (OR AS. d.	A CONSEQUENCE OF): A CONSEQUENCE OF):	melan	se given in Pe	Cand His c	AUTOPSY I	ANALABLE PRIOR TO
	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted evente resulting in deeth) LAST	b. DUE TO (OR AS. DUE TO (OR AS. DUE TO (OR AS. d.	A CONSEQUENCE OF): A CONSEQUENCE OF):	melan	se given in Pe	Cand His c	MED†	AWAILABLE PRIOR TO COMPLETION OF CAUSE
	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted evente resulting in deeth) LAST PART II. Other aignificant condition	DUE TO (OR AS DU	A CONSEQUENCE OF: A CONSEQUENCE OF): but not resulting in the	me underlying ceus		1 TYES	MED†	AWAILABLE PRIOR TO
	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted evente resulting in deeth) LAST	DUE TO (OR AS DU	A CONSEQUENCE OF: A CONSEQUENCE OF): but not resulting in the	me underlying ceus		1 TYES	MED†	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted evente reculting in deeth) LAST PART II. Other aignificant condition DID TOBACCO USE CONTI	DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO CAUSE C	A CONSEQUENCE OF): A CONSEQUENCE OF): DEATH YES 28. PLACE OF DEATH (C.	ne underlying ceus		1 TYES	MED†	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evente reculting in deeth) LAST PART II. Other aignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	DUE TO (OR AS DU	A CONSEQUENCE OF: A CONSEQUENCE OF: but not resulting in the consequence of: DF DEATH YES 28. PLACE OF DEATH (CONSEQUENCE)	ne underlying ceus	NCERTAIN	1 TYES	MED†	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted evente reculting in deeth) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO CAUSE CONTRIBUTE CONTRIBUTE CONTRIBUTE CONTRIBUTE CONTRIBUTE CONTRIBUTE CONTR	A CONSEQUENCE OF: A CONSEQUENCE OF: but not resulting in the consequence of the consequ	NO UNTROCK ONLY ONLY AND UNITED BY AND UNITE	NCERTAIN	1 TYES	NO NO	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN: MEDICAL	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evente reculting in deeth) LAST PART II. Other aignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	DUE TO (OR AS DU	A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): Dot not resulting in the consequence of the cons	Ine underlying ceus The NO UP Check only one) THER: Nursing Home 5 28c. INJURY 2 WORK? M 1 YES	NCERTAIN Residence 6	Other (Specify)	NO NO	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted evente resulting in deeth) LAST PART II. Other aignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be	DUE TO (OR AS DU	A CONSEQUENCE OF: A CONSEQUENCE OF: Dut not resulting in the consequence of the consequ	Ine underlying ceus The NO UP Check only one) THER: Nursing Home 5 28c. INJURY 2 WORK? M 1 YES	Residence 6 2 2 NO	Other (Specify) Bd. DESCRIBE HOW IN Bt. LOCATION (Street a	WO NO	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ED BY PHYSICIAN: MEDICAL	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted evente reculting in deeth) LAST PART II. Other aignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation	DUE TO (OR AS DUE TO	A CONSEQUENCE OF: A CONSEQUENCE OF: Dut not resulting in the consequence of the consequ	Ine underlying ceus The NO UP Check only one) THER: Nursing Home 5 28c. INJURY 2 WORK? M 1 YES	Residence 6 2 2 NO	Other (Specify) 8d. DESCRIBE HOW IN	WO NO	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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ED BY PHYSICIAN: MEDICAL	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted evente reculting in deeth) LAST PART II. Other aignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only)	DUE TO (OR AS DU	A CONSEQUENCE OF: A CONSEQUENCE OF: A CONSEQUENCE OF: Dut not resulting in the consequence of: 28. PLACE OF DEATH (Consequence) 28b. Time Of injury Y — At home, tarm, stree or colly)	NO UP Check only one) THER: Nursing Home 5 28c. INJURY AT WORK? M 1 YES t, factory, office	Residence 6 22 NO 24 ace, end due to	Other (Specify) Bd. DESCRIBE HOW IN St. LOCATION (Street a City or Town, State)	JURY OCCURED NO Number or Run There is stated.	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted evente reculting in deeth) LAST PART II. Other aignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only)	DUE TO (OR AS DU	A CONSEQUENCE OF: A CONSEQUENCE OF: A CONSEQUENCE OF: Dut not resulting in the consequence of: 28. PLACE OF DEATH (Consequence) 28b. Time Of injury Y — At home, tarm, stree or colly)	NO UNCheck only one) THER: Nursing Home 5 28c. INJURY AT WORK? M 1 YES 2 t, factory, office	Residence 6 22 NO 24 ace, end due to	Other (Specify) ad. DESCRIBE HOW IN St. LOCATION (Street a City or Town, State) the cause(s) end man- ne, date and place, end	JURY OCCURED NO Number or Run There is stated.	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Rel Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST PART II. Other aignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER	DUE TO (OR AS DU	A CONSEQUENCE OF: A CONSEQUENCE OF: A CONSEQUENCE OF: Dut not resulting in the consequence of: DF DEATH YES 28. PLACE OF DEATH (Consequence) 28b. Time Of invariant in the consequence o	NO UNCheck only one) THER: Nursing Home 5 28c. INJURY AN WORK? M 1 YES t, factory, office the time, date end plan my opinion, death oc	Residence 8 20 20 NO 24 ace, end dus to coursed at the time	Other (Specify) ad. DESCRIBE HOW IN St. LOCATION (Street a City or Town, State) the cause(s) end man- ne, date and place, end	NJURY OCCURED And Number or Run There is stated.	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Rel Route Number,
COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted evente resulting in deeth) LAST PART II. Other aignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	DUE TO (OR AS DU	A CONSEQUENCE OF: A CONSEQUENCE OF: A CONSEQUENCE OF: Dut not resulting in the consequence of: DF DEATH YES 28. PLACE OF DEATH (Consequence) 28b. Time Of invariant in the consequence o	NO UNCheck only one) THER: Nursing Home 5 28c. INJURY AT WORK? M 1 YES: t, factory, office the time, date end plumy opinion, death oc	Residence 6 22 NO 26 NO	Other (Specify) Bd. DESCRIBE HOW IN Bt. LOCATION (Street a City or Town, State) the cause(s) end manner, date and place, end	NJURY OCCURED And Number or Run There is stated.	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Rel Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST PART II. Other aignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER	DUE TO (OR AS DU	A CONSEQUENCE OF: A CONSEQUENCE OF: A CONSEQUENCE OF: DEATH YES 28. PLACE OF DEATH (Competition of the control of the cont	NO UP Check only one) THER: Nursing Home 5 St, factory, offica the time, date end plimy opinion, death oc	Residence 6 22 20 NO 26 22 NO 26 26 29 Suite 1	Other (Specify) Bd. DESCRIBE HOW IN Bt. LOCATION (Street a City or Town, State) the cause(a) and man te, date and place, and	HJURY OCCURED AND MANUAL MANU	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY 1 YES 2 NO Rel Route Number, Re(e) and manner es stated.
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted evente reculting in deeth) LAST PART II. Other aignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	DUE TO (OR AS DU	A CONSEQUENCE OF: A CONSEQUENCE OF: A CONSEQUENCE OF: Dut not resulting in the consequence of: DF DEATH YES 28. PLACE OF DEATH (Consequence) 28b. Time Of invariant in the consequence o	NO UP Check only one) THER: Nursing Home 5 St, factory, offica the time, date end plimy opinion, death oc	Residence 6 22 20 NO 26 22 NO 26 26 29 Suite 1	Other (Specify) Bd. DESCRIBE HOW IN Bt. LOCATION (Street a City or Town, State) the cause(s) end manner, date and place, end	HJURY OCCURED AND MANUAL PROPERTY OF RUE AND AND AND AND AND AND AND AND AND AND	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY 1 YES 2 NO Rel Route Number, Re(e) and manner es stated.



TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bar be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. FOR

1 - STATE REGISTRAR	`	011112 01 1	C		ICATE				MENTAL	REG. NO).		
1. DECEDENT'S NAME (First, Midd		- D	DVDD						2. DATE	OF DEATH	MY	YEAR	3. TIME OF DEATH
	MARY	E.	BYRD						Jan.		199		3:40 P
4. SOCIAL SECURITY NUMBER		SEX	6. AGE (In yrs. le:		IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS.	(Month	OF BIRTH , Day, Year)		8. BIRTH Counti	IPLACE (State or Foreign y)
215-36-0352		☐ M 2 🔀 F	87	YRS.					Aug.	8, 1	907	Ma	aryland
9a. FACILITY NAME (If not institution	on, give street	and number)			9b. CITY,	TOWN C	R LOCATIO	ON OF DE	EATH		9c. CO	JNTY OF D	EATH
SALISBURY NURS RESIDENCE OF DECEDI 10a. STATE 10b. Maryland		REHAB	CENTER		SAL	ISBU	JRY,	MD.			WIC	OMICO)
RESIDENCE OF DECEDI	COUNTY			100 CIT	Y, TOWN O	D I OCAT	101						tod. INSIDE CITY
Maryland		omerset		100, 011	i, iowii o		risf:	i a 1 d					LIMITS?
		JIICI SCO		<u></u>									1 TYES 2 X NO
100. STREET AND NUMBER 3053 Lawsonia 11. MARITAL STATUS	Road					101	. ZIP CODE	218	17		10g. CI		S.A.
11. MARITAL STATUS			T EVER IN U.S. AF						NIC ORIGIN	? (Specify Ye	e or No-	14. RACE	— American Indian, c, White, atc.
3 Wildowed 4 Divorced	led	IF YES, GIVE V					2 NO			ilcen, etc.)		Speci	White
15. DECEDEN (Specify only high Elementary/Secondary (0-12) Grade 6 17. FATHER'S NAME (First, Middle,	T'S EDUCATE	ION Poleted			USUAL OC				16b.	KIND OF BU	SINESS/IN		
Elementary/Secondary (0-12)		college (t-4 or 5	Ma	Do NOT u	work done d se retired.)	luring mo	st of workin	g					
Grade 6	_		Hou	ısewi	fe					Home	2		
17. FATHER'S NAME (First, Middle,	Last)						18. MOTH	IER'S NA	ME (First, N	fiddle, Maiden	Sumame)		
John Fieldy L	ord						1	Bert	ha Ma	ae Nel	son		
	rint)		19	b. MAILING	ADDRESS	(Street a	nd Number	or Rural I	Route Numb	er, City or Tow	vn, State, Z	ip Code)	
Donald W. Byr	d (Sor	n)		3053	Lawso	onia	Rd.	- C	risfi	ield,	MD	21817	7
20e, METHOD OF DISPOSITION 1 ☆ Burlel 2 ☐ Cremation 3	□ Remount	Linna State	20b. PLACE	ANDDATE	OF DISPOSI	TION (Na	me of		DATE	20c. LC	CATION -	City or To	wn, State
4 Donation 5 Other (Spec		trom State	Sunny	ematory or d	other place) • Memo	oria	1 Par	rk-1	/29/9	95	Cris	field	d, MD
21. SIGNATURE OF FUNERAL SEE	VICE LICENS	EE /	1	/	22. N	NAME AN	D ADDRES	S OF FA	CILITY		-		
Nobet 1	1/30	ack	course	١.						uneral			
Robert H. 23. PART I. Enter the diseas	Brads	shaw, J	r. U	noth Do	30	06 W	. Ma	in S	t (Crisfi	eld,	MD	21817
shock, or heart	failure. Liat	only one cau	ae on each line	eatti. Do i	not enter	the mo	ue or ayı	ng, suci	n as cerd	lac or reap	iratory a	reat,	Approximate Interval Between
IMMEDIATE CAUSE (Final disease or condition		63		1									Onset and Deat
resulting in death)	a	13/0	ATER	AL	- 1	Ne	up	ron	1A				1xxx
		A-011	OR AS A CONSE	OUENCE O	*): V		7	^					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		DUE TO	(OR AS A CONSE	OUENCE O	De v	var	uco	0					
if any, leading to immediate cause. Enter UNDERLYING					. ,.								j
CAUSE (Disease or Injury that initiated events	c_	DUE TO	(OR AS A CONSE	OUENCE O	F):								<u> </u>
reaulting in death) LAST	18 5												1
J	d												
PART II. Other algnificant co	onditiona co	ontributing to	death but not	resulting	In the unc	derlying	cause g	lven in	Part i.	24s. WAS AN		24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
<u> </u>										t TYES	4		COMPLETION OF CAUSE OF DEATH?
									ĺ	-			1 TYES 2 NO
DID TOBACCO USE (25. WAS CASE REFERRED TO MED EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH	CONTRIB	UTE TO CA	USE OF DEA	TH Y	ES 🗆 N	10 🗆	UNC	ERTAIN	V RI				
25. WAS CASE REFERRED TO MED	DICAL				TH (Check o				1				
1 YES 2 NO		OSPITAL:	ER/Outpatient 3	□ DOA	OTHER 4 Nursi		5 🗆 Re	aldenca	8 Other	(Specify)			
27. MANNER OF OEATH		28a. DATE OF	INJURY	28b. TIM	E OF	28c. INJI	JRY AT		_	CRIBE HOW	INJURY OC	CUREO	
	ng lastion	(Month, D	ay, Year)	tN.	JURY M	1 Y	RK? 'ES 2 🗌	NO					
2 Cutatda		28e. PLACE D	F INJURY — At ho	ome, term,	street, facto	ery, office			281, LOCA	ATION (Street	and Numbe	r or Rural F	loute Number.
29a. CERTIFIER 1 CERTIFIN Check only 1 CERTIFIN DE Check only 1 CERTIFIN DE Check only 1 CERTIFIN Check only 1 CERTIFIN Check only 1 CERTIFIN Check only 1 CERTIFIN Check only 1 CERTIFIN Check only 1 CERTIFIN Check only 1 CERTIFIN Check only 1 CERTIFIN CHECK ONLY 1		building,	atc. (Specify)					i	City o	or Town, State			
29a. CERTIFIER	O BUYCICIA	I. To the best of			CATTON NA			7 1 2 2 2 2 2 2					·
(Check only one)			my knowledge, de xemination and/or) and menner as stated.
D							29c. LICE	NSE NUM	/BER		I and no	E SIGNED	
													(Month Day Year)
296. SIGNATURE AND TITLE OF C		A	1.0					29	ar		290. DA	1/2-	(Month, Day, Year)
296. SIGNATURE AND TITLE OF C	ERTIFIER	OMPLETED CALL	SE OF DEATH (ITE	M 27) (Tuna	. Print)		0	398	33		▶	1/27	(Month, Day, Year)
296. SIGNATURE AND TITLE OF C	SON WHO CO	OMPLETED CAUS					0	398	33		•	1/27	(Month, Day, Year)
296. SIGNATURE AND TITLE OF C	SON WHO CO		SE OF DEATH (ITE			DR.	0	398	33	D. 21	•	1/27	(Month, Day, Year)



	1 - STATE REGISTRAR	SIMIE UT M				OF DE		MENIA	L HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)	2		Hov	VARD	OLIVE		2. DATE	OF DEATH	AY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	/	Field	BRI	NSFI	ELD, SI	R	1	3	0	95	10 00 AM
	220-34-9397	5. SEX	6. AGE (In yrs. last	YRS.	MONTHS	DAYS HOUR	B MIN.	(Mont	OF BIRTN h, Day, Year) E 20,	1924	Country	PLACE (State or Foreign Y) RYLAND
	9a. FACILITY NAME (If not institution, give	street and number)			9b, CITY,	TOWN OR LOC	ATION OF E		207		NTY OF DE	
DIRECTOR	UNIV.OF MARYI	AND HOS	PITAL		BA	LTIMO	RE			BAL	TIMO	DRE
EC	10a. STATE 10b. COUNT				Y, TOWN OF							10d. INSIDE CITY
	MARYLAND DOR	CHESTER		V	IENN	Α						LIMITS? 1 YES 2X NO
FUNERAL	10e. STREET AND NUMBER					10f. ZIP C				10g. CIT	IZEN OF W	HAT COUNTRY?
JNE	5031 RHODESDA	LE-VIEN		MED	40.44	218					USA	
BY FL	1 Never Married 2 X Married 3 Widowed 4 Divorced	FORCES? 1	YES 2 WN	0	16	AS DECENDEN yes, specify Co	iban, Maxic	en, Puerto	17 (Specify Yea Rican, etc.)	n or No—	14. RACE Black Specif	— American Indien, , Whita, stc. ly: WHITE
ED	15. DECEDENT'S EDU (Specify only highest grade		16a. DEC	CEDENT'S	USUAL OCC	CUPATION iring most of wo	alain n	168	. KIND OF BU	SINESS/INI	DUSTRY	
F	Elementary/Secondary (0-12)	College (1-4 or 5+)		Do NOT us	se retired.)	inng most of wo	nung					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			FAR	MER					ARMI	NG	
	BALVIN B. BRI	NSFTELD.	SR.			18. M			Middle, Maiden	Surname)		
) BE	19a. INFORMANT'S NAME (Type/Print)	HOI THID		MAILING	ADDRESS	Street and Num				n, State, Zip	Code)	
٩	ANNE D. BRINSF	'IELD				ESDAL						A, MD
	20a METNOD OF DISPOSITION 1 Disposition 2 Cremation 3 Ren 4 Donation 6 Other (Specify)	noval from State	20b. PLACE A cemetery, cren EAST N	natory or o	ther piece)		мет	OAT		CATION —		wn, Stata MARKET, M
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	III I	LLM	22. N	AME AND ADD	RESS OF F	CILITY				MARKEI, M
	JOHN Z.	MEASER	20)		NE	WNAM	FUNE	RAL	HOME	P.A	· CMOX	
	23. PART I. Enter the diseases, or shock, or heart fellure.	complications thet	consen the det	ntn. Do i	not enter t	he mode of	dying, aud	ch aa care	diac or reap	retory en	STON	Approximata
		a. CORO			cula.	v Dis	ease	2				Interval Batween Onset and Death
_		Selv	SIS	DENCE O	r):							14 days
ᅙ	Sequentially list conditions, if any, leeding to immediate	DUE TO (OR AS A CONSEO									14 days
2	cause. Enter UNDERLYING CAUSE (Disease or injury		OR AS A CONSED									36 days
CERTIFICATION	that initisted events reculting in death) LAST		Betes	UENCE O	r):							14415
11	PART II OH II III	d										11913
DICAL	PART II. Other algorificant condition Hyperteinsion	/ ^ /	monary		In the und	erlying caus	e given in	Part I.	24a. WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MED	7/											1 TYES 2 NO
PHYSICIAN:	DID TOBACCO USE CONT	RIBUTE TO CAL			S N		ICERTAI	N 🗆				
SICI	EXAMINER?	HOSPITAL:			OTHER:				0.500			
Ĕ	27. MANNER OF DEATH	28a. DATE OF I	NJURY	28b. TIM	E OF 2	8c. INJURY AT	Hasigence		CRIBE HOW I	NJURY OC	CURED	
BYF	1 Natural 5 Pending 2 Accident Investigation	(WORLD), Del	y, rear)	INJ	URY M	WORK?	□ NO					1
COMPLETED	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF building, a	FINJURY — At hon ttc. (Specify)	ne, farm, s	Rreet, factor	y, office		28f. LOC City	ATION (Street a or Town, State)	and Number	or Rural Ro	oute Number,
7	29e. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of r	my knowledge, dea	th occum	d at the tim	e, data and pla	ca, end due	to the cau	se(s) end mer	ner sa stel	ed.	
Ö	one) 2 MEDICAL EXAMINI	ER: On the beals of ex	emination and/or in	nve atigatio	n, in my opi	nion, death oc	cured at the	time, data	and place, an	d due to th	a cause(a)	and manner as stated,
O BE	296. SIGNATURE AND TITLE OF CERTIFIE Mitherel 2	hadker	rch	M	.D.	29c. L	243	MBER 846	EZS	29d. DAT	E SIGNED	(Month, Day, Year) 30,95
۲	30. NAME AND ADDRESS OF PERSON WITH Chael Zho	10 COMPLETED CAUSE	e of OEATH (ITEM	27) (Type,	Gres	ch St	reet	-, U.	n, Me	1.,0	7 8u	30,95
	31. DATE FILEO (Month, Day, Year) JAN 31 199	32. DEGISTRAR	rs signatures	ball				/				



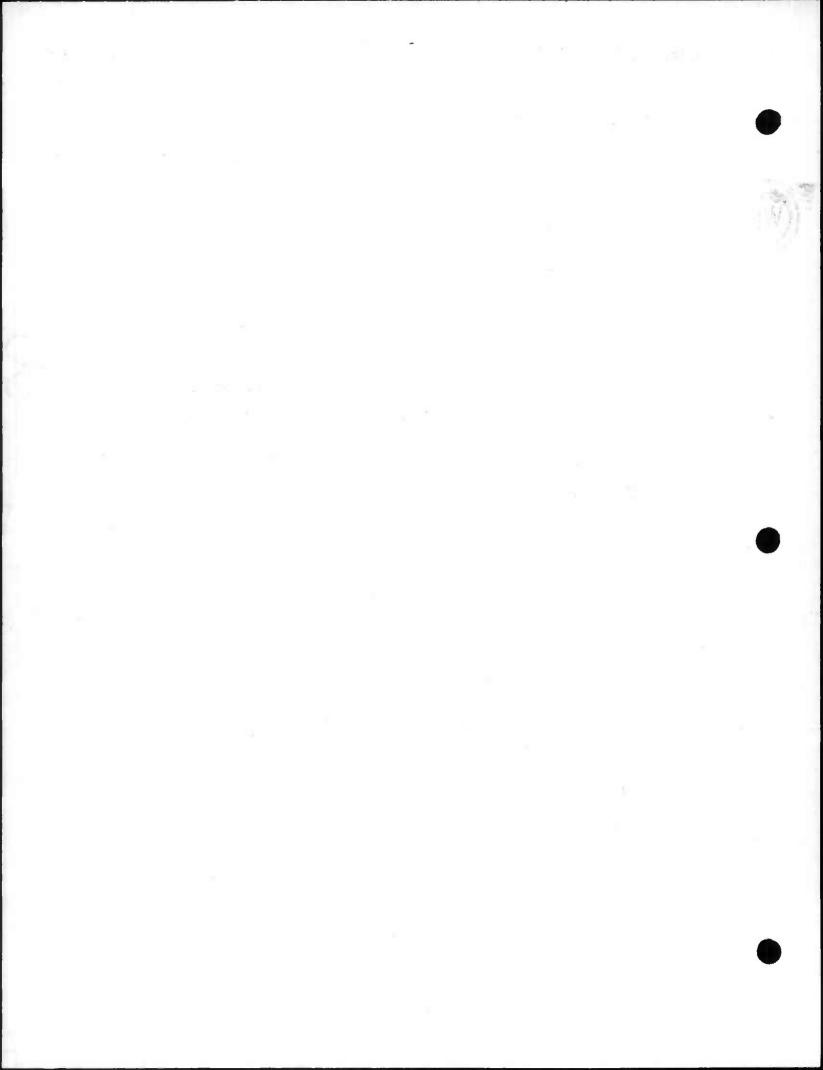
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE RUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

DHMH-16 Rev 1/89



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been stoned by the attending physician and connected filled in by the funeral director have 5 should be use 35 the burial branch as
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

2

BY PHYSICIAN: MEDICAL CERTIFICATION

COMPLETED

8

2

31. DATE FILED (Month, Day, Year)

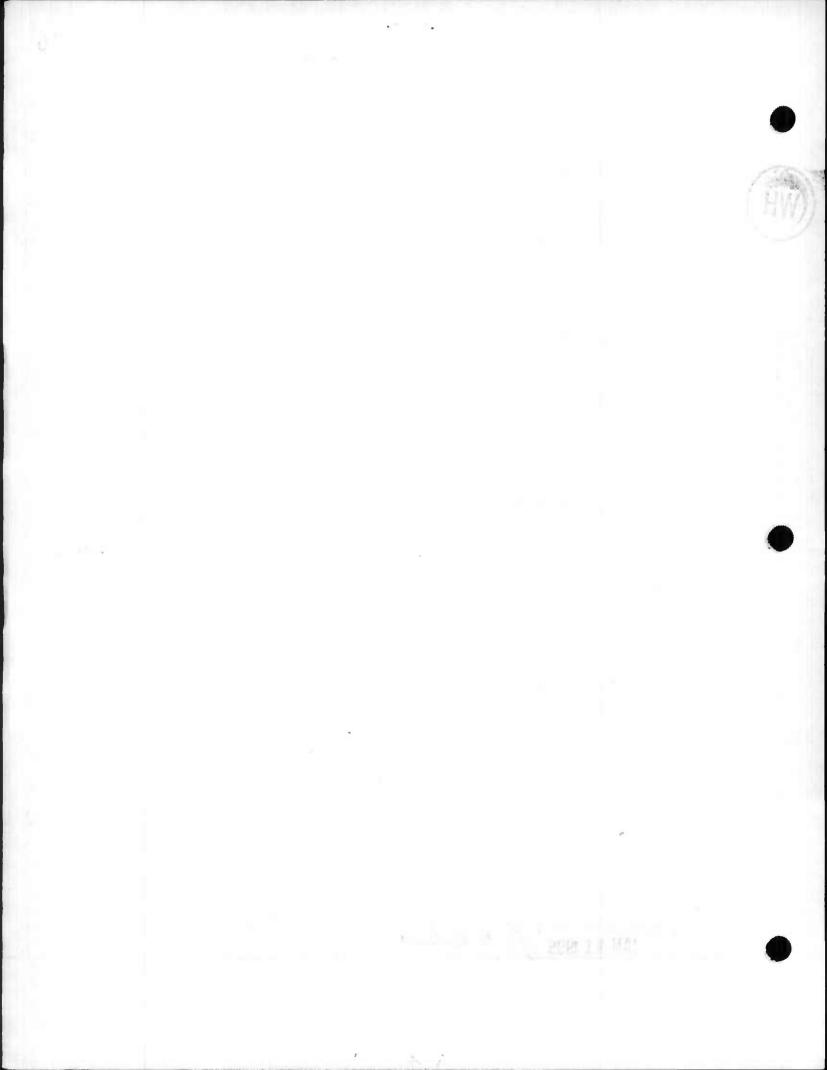
JAN 31

32. JEGISTRAR'S SIGNATURED

												95	0458
	1 - FOR STATE REGISTRAR		STATE OF I	MARYLAI	ND / DEPAR	TMENT	OF I	HEALTI DEA	AND TH	MENTAL HYGIEN			
3	1. DECEDENT'S NAME (FISSE Helen Eli		Butler							2. DATE OF DEATH MONTH D	AY 1	YEAR 95	3. TIME OF DEATH
1	4. SOCIAL SECURITY NUME 219-42-905		5. SEX	6. AGE (In	yrs. last birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDI	MIN.	June 8,194	45	Count	NPLACE (State or Foreign
TOR	Pasidence Residence (11159	. 11	load			orto		TION OF DI			INTY OF D		
DIRECTOR	10a. STATE MD	Kent				orto		TION					10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	106. STREET AND NUMBER 11159 Pott	sRoad					10	1. ZIP COI	5 7 8		10g. CI	USA	WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Merried 2 3 Widowed 4 Divo	The second second	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 NO		f yes, sp	CENDENT Hecify Cut	an, Mexica	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	s or No—		E — American Indian, k, White, atc. My: Black
COMPLETED	15. DEC (Specify only Elementary/Secondary (0 11 th	EDENT'S EDUC y highest grade 1-12)	CATION completed) College (1-4 or 5		6a. DECEDENT'S (Give kind of the Do NOT us Lin	work done	during mo	ost of work	uing	166. KIND OF BU			Company
BE CO	17. FATNER'S NAME (First, M Harrison C	ooper	·.							ME (First, Middle, Malden ett Whye			

Bernett Whye 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dora Lee Butler 11159 Potts Road, Worton, Maryland21678 20a. METHOD OF DISPOSITION

15 Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 28c. LOCATION - City or Town, State ty Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 6 ☐ Other (Specify) conselery, crematory or other clace)
Mt. Olive Church Cemetery Butlertown, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Bennie Smith Funeral Home P.O. 691 Dover, De 19903 Dover, De 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line interval Batween **Onset and Death** disease or condition resulting in death) metastatic reast cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS insulin dependent AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO DF DEATH? 1 TES 2 NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: 1 YES 2 16 1 | Inpetient 2 | ER/Outpetient 3 | DOA ne 5 (Nesidence 6 (Other (Specify) 26a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF 26d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO 2 Accident 26a. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Nomicide 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d, DATE SIGNED (Month, Day, Year) 033514 -24 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) Med BL Cheste 21620



TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE REGISTRAR			CERTIF	ICATE	OF	DEAT	THI .	MENTA	REG. NO)		
1. DECEDENT'S NAME (First, Middle, Last)									OF DEATH			3. TIME OF DEATH
The Ima	Amelia		rrios	1				_	uary :	30 19	_	6:30A M
	5. SEX		: lest birthday)	IF UNDER 1	DAYS	IF UNDER	24 HRS. MIN.	(Mont	OF BIRTH		Count	
433-05-2208 98. FACILITY NAME (If not institution, give st		90	THS.	01.0000					9 190	_	<u> </u>	isiana
Annapolis Convale	entrans-	ntor		9b. CITY,	napo		ON OF DE	HTA		- 1	NTY OF D	
RESIDENCE OF DECEDENT	SCEIIL CE			A	шар	0115				Ann	e Ai	unde l
10a. STATE 10b. COUNTY	Arundel		10c. CIT	Y, TOWN OF		i dso	nvil	اه				10d. INSIDE CITY LIMITS?
100. STREET AND NUMBER	7 ii dildoi			_		ZIP CODE		10		10. 0/7	17711 00 1	1 YES 2 NO
1118 Quince Appl	e Place	1.372			1 101.		1035					States
11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S.	ARMED						N? (Specify Ye	s or No—	14. RACI	E — American Indian, k, Whita, atc.
1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W		NO		yes, spec		n, Maxicar Specify		Ricen, etc.)			k, White, atc. ^{thy:} White
A-												vviiite
15, DECEDENT'S EDUC (Specify only highest grade		16a.	(Give kind of	work done de			g	168	. KIND OF BU	ISINESS/IN	DUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5 +		Homema						H	ome		
17. FATHER'S NAME (First, Middle, Last)				_		18. MOTH	IER'S NAI	ME (First,	Middle, Maider	Surname)		
C.J. Venissat							Ida	Dor	len			
19a. INFORMANT'S NAME (Type/Print)			19b. MAJLINO									
Melanie Graw			1118	Quino	ce A	pple	Pla	ce [Davids	onv i I	le,	MD 21035
20a. METHOD OF DISPOSITION 1 Burial 2 Commetter 3 Remo	oval from Stata	cemetery.	CEANDDATE O	ther plecel				DAT		OCATION —		
4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	CHOCK	IFt.	Lincol	n Cre	ema t	ory	2/1/	95	Br	<u>en two</u>	od,	Maryland
21. SIGNATURE OF FUNERAL SERVICE LIC	D DI			22. N	AME AND	ADDRES	S OF FAC	OUTLINE	hn M.	Tayl	or F	uneral Home
Daine of	Thill	me		14	17 Di	iike i	of G	ilouo	ester	St	Anna	polis, MD
93 DADY I Enter the discours I				- 1								porra, IVD
23. PAR I. Enter the diseases, or o shock, or heart failure. I	omplications that	caused the	death. Do r	- 1								Approximate
immediate CAUSE (Final	omplications that List only one cau	se on each i	iine.	not enter t	the mod	e of dyl	ng, euch	aa can	diac or resp	eiratory sr	res1,	Approximate Interval Batween
snock, or heart faiture.	omplications that List only one cau	se on each i	iine.	not enter t	the mod	e of dyl	ng, euch	aa can	diac or resp	eiratory sr	res1,	Approximate Interval Batween
iMMEDIATE CAUSE (Final disease or condition	List only one cau	se on each i	iine. Wa	not enter t	the mod	e of dyl	ng, euch	aa can	diac or resp	eiratory sr	res1,	Approximate Interval Batween
iMMEDIATE CAUSE (Final disease or condition	DUE TO	OR AS A CON	IINE. SEOUENCE OF	ro1 enter t	the mod	e of dyl	ng, euch	aa can	diac or resp	eiratory sr	res1,	Approximate Interval Batween
iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	DUE TO	by (IINE. SEOUENCE OF	ro1 enter t	the mod	e of dyl	ng, euch	aa can	diac or resp	eiratory sr	res1,	Approximate Interval Batween
immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO	OR AS A CON	SEQUENCE OF	F):	the mod	e of dyl	ng, euch	aa can	diac or resp	eiratory sr	res1,	Approximate Interval Batween
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if smy, leading to immediate cause. Enter UNDERLYING	DUE TO	OR AS A CON	SEQUENCE OF	F):	the mod	e of dyl	ng, euch	aa can	diac or resp	eiratory sr	res1,	Approximate Interval Batween
immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or injury that intilated events resulting in death) LAST	DUE TO	(OR AS A CON	ISEQUENCE OF	(F):	P+	e of dyli	ng, euch	as con	diac or resp	eiratory sr	res1,	Approximate Interval Batween
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CON	ISEQUENCE OF	(F):	P+	e of dyli	ng, euch	as con	diac or resp	AUTOPSY	rest,	Approximate Interval Batween Onset and Dasth
immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or injury that intilated events resulting in death) LAST	DUE TO	(OR AS A CON	ISEQUENCE OF	(F):	P+	e of dyli	ng, euch	as con	i K	AUTOPSY RMED?	rest,	Approximate Interval Batween Onset and Dasth WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO DUE TO DUE TO DUE TO	(OR AS A CON	ISEQUENCE OF	(F):	P+	e of dyli	ng, euch	as con	24a. WAS AI PERFO	AUTOPSY RMED?	rest,	Approximate Interval Batween Onset and Dasth WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
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32. REGISTRAN'S SIGNATURE Pardell

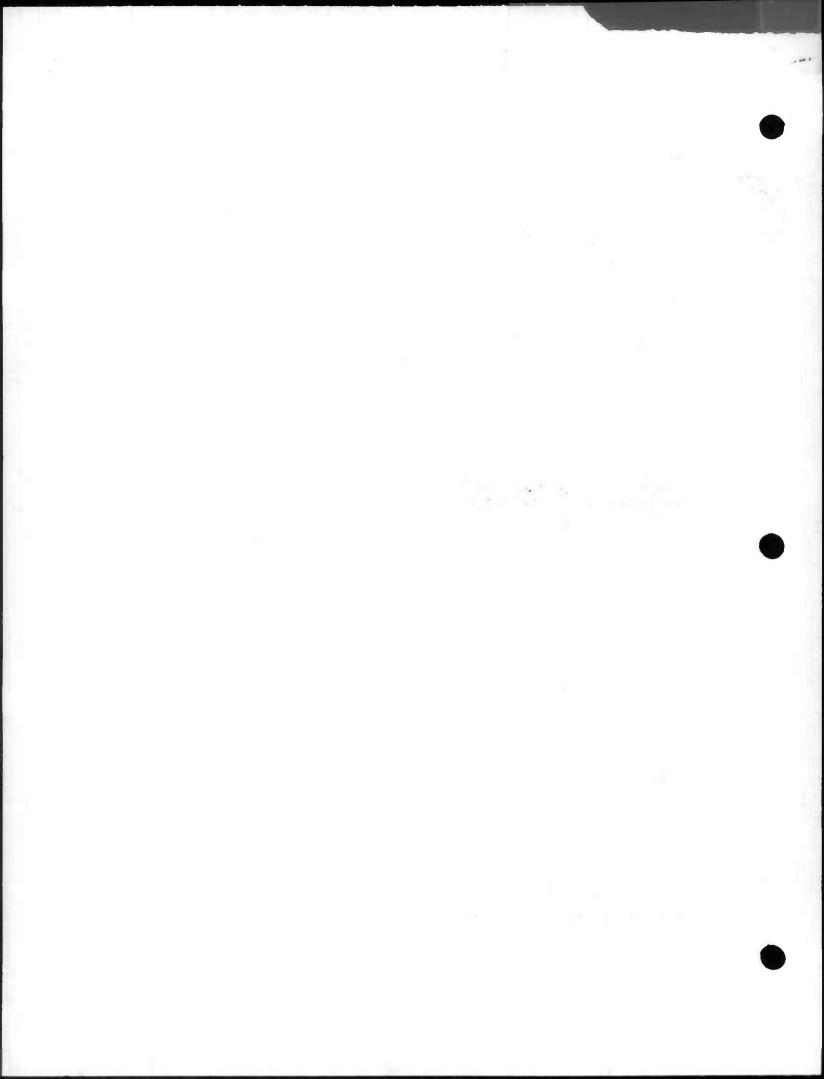
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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burish frames be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. nours after death. Page 6 may be retained by the hospital or attending physician BALTIMORE, MARYLAND 21215-0020 IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Month.

DHMH-16 Rev 1/89



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR		CE	RTIFIC	ATE O	F DEATH	E	REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH												
	Mary Frances				Feb 04 19			95	95 10.30 Pm				
	4. SOCIAL SECURITY NUMBER 217-42-2298	1 M 2 F	M 2 F 67 YRS. MONTHS			IF UNDER 24 HRS. 7. DATE OF BIRTH AMORT. OF SHIP AUG. 21 YEAR AUG. 21 YEAR			8. BIRTHPLACE (State or Foreign County) Washington D				
	9e. FACILITY NAME (If not institution, give s			9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH					
DIRECTOR	Chesapeake Manor	Extended C	are Cer	entre Arnold					Anne Arundel				
EC										10d. INSIDE CITY			
	MD Anne		Annapolis							1 XYES 2 NO			
FUNERAL	38 Southgate Ave	nue		101. ZIP CODE 21401			10g. CITIZEN USA			EN OF W	N OF WHAT COUNTRY?		
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Married 3 Divorced	12. WAS DECEDENT EV FORCES? 1 IF YES, GIVE WAR	YES 2X NO	2 NO If yes, specify Cuban, Me			exican, Puerto Rican, etc.)				14. RACE — American Indian, Black, White, etc. Specify: white		
	15. DECEDENT'S EDU (Specify only highest grade	CATION			UAL OCCUPA		16b. KII	ND OF BUS	INESS/IND	USTRY			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work do life. Do NOT use retired			most of working							
MP		4	Homemaker			Own Hom			e				
BE CO	17. FATHER'S NAME (First, Middle, Last) Richard Francis					ME (First, Midd Caroly	Middle, Maiden Surname) Dlyn Morris						
0	19e. INFORMANT'S NAME (Type/Print)	MAILING AD	DRESS (Street	et and Number or Rural i	Route Number,	City or Towi	, Stete, Zip	Code)					
-	Bruce A. Beckner					Ave/Anna	polis/	MD 2					
	20s, METHOD OF DISPOSITION 1 A Burtel 2 Cremetion 3 Rem 4 Donetion 5 Other (Specify)	cemetery, cren St. Ar	atory or other	olace)		2/9 Annapolis MD							
	21. SIGNATURE OF FUNERAL SERVICE LI	DI Da M	EE 22. NAME AND ADDRESS (of Facility rial Services				
	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Finel	complications that ca List only one cause	used the dea on each line.	th. Do not	enter the r	node of dying, suc	h as cardiec	or respi	ratory arre	est,	Approximate interval Between Onset and Death		
ļ	disease or condition resulting in death)	a. Carfutes	AS A CONSEC	UENCE OF):					_				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury C. C												
EH	that initiated evente resulting in death) LAST												
- 1											WERE AUTOPSY FINDINGS		
DICAL							PERFORMED? 1 □ YES 2 1 100			AVAILABLE PRIOR TO COMPLETION OF CAUSE			
ME											DF DEATH? 1 YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		0	26. THER:	PLACE OF DEATH (Ch	eck only one)						
2	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER			Nursing H	ome 5 Residence				11050			
	1 Natural 5 Pending	(Month, Day, Y		INJUR	γ	WORK?	28d. DEŞCRI	BE NOW II	IJUNY OCC	UHED			
ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	2 Accident 3 Suicide 5 Could not be building, size, (Specify) 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, size, (Specify) 26f. LOCATION (Street and Number or Rural Route Number or Building, size, (Specify)								loute Number,			
	29e. CERTIFIER												
COMPLETED		CIAN: To the best of my) and menner on stated.		
מנו	296. SIGNATURE AND TITLE OF CERTIFIE					29c. LICENSE NUI	WBER		29d. DATE	SIGNED	(Month, Day, Year)		
0	Nichtn A. CA	WUSAMD				D1668	0		1 2	1618	5		
-	30. NAME AND ADDRESS OF PERSON WH Nicholas Capozzo					lis MD 214							
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE		*-								
FEB 07 1995 Julia Davidson Revolate													

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Thours after death, Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-train be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If tem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

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	1 - STATE REGISTRAR	SIAIE UF MA			CATE OF		D MICI	NTAL HYGIEN REG. NO.	Ė			
- 3	1. DECEDENT'S NAME (First, Middle, Last)							DATE OF DEATH	3. TIME OF OEATH			
1	Charles	Neal			Boyden			bruary	8:05 A M			
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	. AGE (In yrs. lest birt	thday) I	IF UNDER 1 YEAR	IF UNDER 24 HR	s. 7.	DATE OF BIRTH	2 9	8. BIRTHP	LACE (State or Foreign	
	216-16-4366	1 🙀 M 2 🗆 F	74 Y	rrs.	ONTHS DAYS	HOURS MIN	T.	(Month, Day, Ybar) an. 16	192	Country)	OH	
	9a. FACILITY NAME (If not institution, give st	treet and number)		9	b. CITY, TOWN (R LOCATION O			9c. COUNTY OF DEATH			
H.	Physicians Mem	orial Ho	enital		Ιο	Plata						
DIRECTOR	RESIDENCE OF DECEDENT								Сп	ar1e	S	
RE	10e. STATE 10b. COUNTY			10c. CITY, TOWN OR LOCATION						1	10d. INSIDE CITY	
	MD Char	:les		<u>Bel</u>	Alton	1				1	T YES 2 KNO	
₹AL	10e. STREET AND NUMBER			10f. ZIP CODE					10g. CITIZ	ZEN OF WH	IAT COUNTRY?	
FUNERAL	9380 Aires Dr.					2061	1			U.S	.A.	
5	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT E FORCES? 1)		CENDENT OF HISPANIC ORIG				14. RACE - Black,	- American Indien, White, etc.	
ВУ	3 Wildowed 4 Olvorced	IF YES, GIVE WAR				2 NO Specify:						
	15. DECEDENT'S EDUC	CATION	44. proces					16b. KIND OF BUSINESS/INDUS			White	
1	(Specify only highest grade	completed)	(Give ki	EDENT'S USUAL OCCUPATION e kind of work done during most of working Do NOT use retired.)				166. KIND OF BUS				
7	Elementary/Secondary (0-12)	College (1-4 or 5+)		'armer				Fa				
COMPLETED	17, FATHER'S NAME (First, Middle, Last)		1 4.	LINC	-	18 MOTHED'S	NAME /	First, Middle, Maiden	rmir	1g		
	Ernest Clifford	ł										
BE	19a, INFORMANT'S NAME (Type/Print)		Eva Elizab 19b. MAILING ADDRESS (Street and Number or Rural Route Num								LLIUIU	
임	Lillian Boyden							on, MD 2				
	20e. METHOD OF DISPOSITION		20b. PLACEAND				MIL		CATION —		n State	
	1 X Buriel 2 Cremation 3 Remo	oval from State	remetery, cremato	y or othe	em. Ga	rdens	21	6/95 W	aldo	rf 1	MD	
	1 X Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Mem. Gardens 2/6/95 Waldorf, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY. 23. NAME AND THE SERVICE CONTROL TO SERVICE SE											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE AREHART-ECHOLS FUNERAL HOME, INC. MO0945 P.O. Box 567 LaPlata, MD 20646											
\dashv	23. PART i. Enter tha diseases, or c	lie	MOO	945	P.O.	ROX 2	6/	LaPlata	, MD	206	646	
	shock, or heart failura. I	Liat only ona causa	on aach lina.	. Do not	anter tha mo	de or dying, i	such as	cardiac or raapii	ratory arra	ast,	Approximate interval Between	
	iMMEDIATE CAUSE (Final disease or condition	0-	1 .		- 1	150			1-		Onset and Death	
- 1	reaulting in death)	a. Care	no re	2v Y G	~ ~	1	arres			31 well		
_	immediate cause (Final disease or condition resulting in death) a. Carelia respiratory arest 3:1/week Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
		16- 0	20100	410	Cana	10-11			0.0	/-	12	
٥ I	Sequentially list conditions,	2. Hemo	R AS A CONSEGUEN	ICE OFI:	Cene	brove	00	culor	ace	cide	nt 2	
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RTIFICATION	cause, Entar UNDERLYING CAUSE (Disease or injury					bori	201	culor	aca	cide	nt 2	
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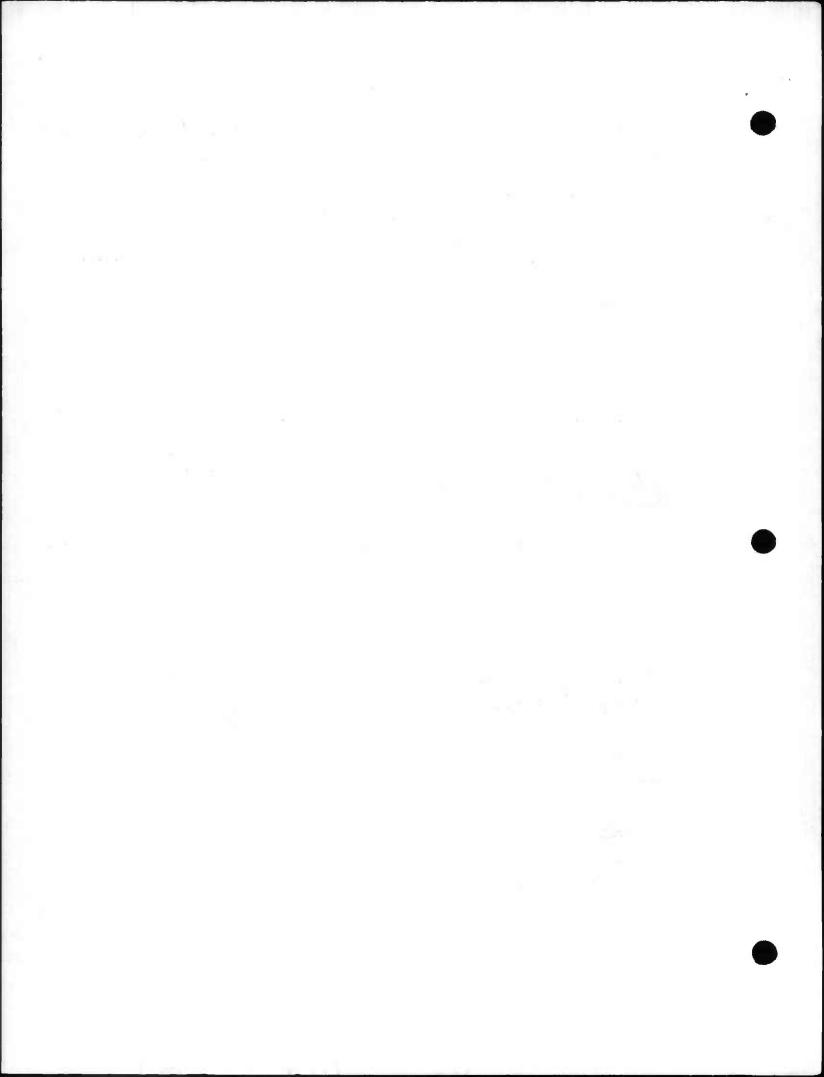
		1 - FOR STATE REGISTRAR	STATE OF MA	ARYL			F HEALTH		MENTAL	HYGIEN REG. NO.	E			
		1. DECEDENT'S NAME (First, Middle, Last) MARY		E	LLEN	В	ENNETT		J ANU	JARY3	1995 1, 19 9	2R 3.	TIME OF DEATH 7:50 P	
D.		4. SOCIAL SECURITY NUMBER 219-16-0904	5. SEX 6. AGE (In yrs. lest birthday) 1 M 2 F 86 YRS.		MONTHS DAYS HOURS MIN.			7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or) Sept. 23.1908 MD						
3 should	TOR 1	98. FACILITY NAME (If not institution, give s PHYSICIANS MEN RESIDENCE OF DECEDENT	treet and number) IORIAL HOSPITAL			96. CITY, TOWN OR LOCATION OF DEATN LA PLATA					9c. COUNTY OF DEATH CHARLES			
L L	IRECTOR	10a. STATE 10b. COUNT				Y, TOWN OR L						10	d. INSIDE CITY LIMITS?	
	AL DI	MD Ch	arles L			LaPlat	101. ZIP CODE			10g. CITIZEN	_	☐ YES 2 🙀 NO T COUNTRY?		
physican burtal-transit	FUNERAL	Box 1085 11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED			20646 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Ye				U.S.A. a or No.— 14. RACE — American Indian,			
5-0020 anding physic as the burnel	B	1 Never Merried 2 Married 3 Widowed 4 Divorced		FORCES? 1 TYES 2 THO IF YES, GIVE WAR OR DATES			Il yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 YES 2 NO Specify:					Specify: Black		
al or atte	COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)		16a. DECEDENT'S (Give kind of life. Do NOT u Homema	work done durin se_retired.)	PATION g most of working	,	18b. (KIND OF BUS	Home	RY		
# & & =	BE COM	17. FATHER'S NAME (First, Middle, Last) Jimmy Neale								ter	Sumame) Neale			
retain 5 sho	10	190. INFORMANT'S NAME (Type/Print) Francis Bennet	t				eet and Number o			0646	n, State, Zip Coo	le)		
. Page 6 may be ral director, page		20a, METNOD OF DISPOSITION 1 Burlel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	20b.	PLACEAND DATE etery, cremetory or called H	OF DISPOSITIO	N (Name of		DATE / 4 / 9	20c. LO	cation – city aPlata			
death fune		21. SIGNATURE OF FUNERAL SERVICE LIN	ENSEE		MOO945	ARE	EHART-	S OF FACE	OLS	FUNE	RAL HO	OME	INC.	
ed within 24 completely fills al, cremation, event, the	Z	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. C L	e Dn ea	the death. Do not line.	not enter the	mode of dyln	ig, auch	ea cerdi	ac or respl	ratory arrest,		Approximate interval Between Onset and Death	
th certificate be ending physician I Hygiene prior to other traus	MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DUE TO (C	OR AS A	CONSEQUENCE O	F):								
ind the		PART II. Other algorificant condition		leath be	ut not resulting	in the under	lying cause gi	iven in i		24a. WAS AN PERFOR	MED?	CO OF	RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH?	
law taw bept.		DID TOBACCO USE CONT	RIBUTE TO CAU					RTAIN	10			1 (YES 2 NO	
2 2 3	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSBITAL:		26. PLACE OF DEA	OTHER:	one) Nome 5 ☐ Rae	Idence	6 🗆 Other	(Specify)				
F # # F	ВУ РН	27. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF IN (Month, Day)	; Year)		M 1 YES 2 NO				28d. DESCRIBE NOW INJURY OCCURED				
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETED	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, etc. (Specify)						281. LOCATION (Street and Number or Rural Route Number, City or lown, State)						
로 IN N	COMPL	298. CERTIFIER (Check only one) 1 CERTIFYING PNYSI ONE) 2 MEDICAL EXAMINE	CIAN: To the best of m R: On the beels of exa-									use(a) an	d manner as stated.	
TO THE HOSPI TO THE FUNER be filed within	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIED		,			29c. LICEN D-2				29d. DATE SIG		rith, Day, Year)	
		KHADAR BAIG, MD			WAY 3C		190]	LA :	PLAT	A,MAI	RYLANI	20	0646	
		FEB 0 3 199	32. REGISTRAR	'S SIGN/	SON-Randal									
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FOR

	1 - STATE REGISTRAR		CERTIFI	CALL OF	DEATH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			3. TIME OF DEATH
	L. LOUIS	SE BLACKST	CEN			Feb 1	0	75	6:39Am
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH			LACE (State or Foreign
	163-24-4648	1 - FEMALE	67 YRS.	MONTHS DAYS	HOURS MIN.	Jan 6, 19	28	PENNS	SYLVANIA
	9a. FACILITY NAME (If not institution, give	,			R LOCATION OF D	EATH	9c. COU	NTY OF DE	ATH
O.	WESTMINSTER N. &	CONV. CENTER	3	WESTM]	NSTER		CAR	ROLL	
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT	ry	10c CITY	TOWN OR LOCAT	ION				for Micips Offy
<u>=</u>	MD 100, STATE CA.	RROLL	LIN	WOOD LOCAT	ION				10d. INSIDE CITY LIMITS?
	10e, STREET AND NUMBER			100	ZIP CODE		10= CIT		1 YES 2 NO
FUNERAL	427 CLEAR RIDGE	RD.			ZIP CODE 217	91	iog. Cit	U.S	AT COUNTRY?
<u>ج</u>	11. MARITAL STATUS	12. WAS DECEDENT EVER I	IN U.S. ARMED			NIC ORIGIN? (Specify Yes	or No.	14 BACE	American Indian
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	If yes, sp	cify Cuban, Maxic	an, Puarto Rican, etc.)	01 140-		- American Indian, Whita, atc.
BY	3 Midowed Man biripered	IF YES, GIVE WAR OR D	AILS	I I IES	2 NO SOO	ny:		WH?	TE
	15. DECEDENT'S EDI (Specify only highest grad		18a. DECEDENT'S	USUAL OCCUPATION ork done during mo		16b. KIND OF BUS	INESS/IN	DUSTRY	
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	e retired.) ER/DAYCA		IDER OWN	ПОМЕ	7	
MP	12		HOMEMAK	EK/DAICA	IKE PROV	IDBK OWN	пом		
COMPLET	17. FATHER'S NAME (First, Middle, Last) CHARLES STAHL					AME (First, Middle, Maiden : IE BAKER	Surname)		
BE									
6	190. INFORMANT'S NAME (Type/Print) RALPH T. BLACKS'T	FN	19b. MAILING	ADDRESS (Street a EAR RID(nd Number or Rural	Route Number, City or Town	, State, Zi	Code) MD	21791
	700	RIAL.							
	1 Buriel 2 Cremetion 3 Rer	201	b.placeanddateo "PIPE"CRE	F DISPOSITION (Na	ma of PIDV	NIT		City or Tow	n, State NDSOR, MD
	4 Donation 5 Other (Specify)		FIFE CKE			2/7			
İ	1100	00/1	0 ,	22. NAME AF	ID ADDRESS OF F		HAICI		a bond
- 43	1 stharine	J. Darly	ar			INDSOR, MD			
	23. PART i. Enter the diseeses, or shock, or heart failure.	complications that cause. List only one cause on a	d the deeth. Do n	ot enter the mo	de of dying, au	ch as cardiec or reepir	atory ar	reat,	Approximata interval Between
	IMMEDIATE CAUSE (Final		C .		1				Onest and Death
	disease or condition resulting in death)	· Massi	ve CL	1A 10	to be	ain			2 Mor
		DUE TO (OR AS	A CONSEQUENCE OF):					
ᇹ	Sequentielly list conditions,	b							
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS /	A CONSEQUENCE OF):					
윤ㅣ	CAUSE (Disease or injury that initiated evente	c. DUE TO (OR AS	A CONSEQUENCE OF):					
ĒΙ	reaulting in deeth) LAST			,					İ
뜅		d							
A	PART II. Other eignificant condition		but not resulting in	n the underlying	cause given in	Part i. 24s. WAS AN			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDICAL	Diabelos	Melitin				1 _ YES 2	NO		COMPLETION OF CAUSE OF DEATH?
뿔	1 experter	25100							YES 2 NO
	I DID TOBACCO USE	CONTRIBUTE TO	CAUSE OF	DEATH '	YES I (N	0 14			
	- DID TODACCO COL	COMINIBOLE TO			120 [
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PL	ACE OF DEATH (C				
	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 inpetient 2 ER/Out	patient 3 DOA	26. PL	ACE OF DEATH (C				
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BE COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES NO 27. MANNER OF DEATH Neture	HOSPITAL: 1 Inpettent 2 ER/Out 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spe SICIAN: To the best of my know IER: On the basis of axaminatic	28b. TIME INJU	26. PL OTMER: INTERING Horn E OF NY M 1	ACE OF DEATH (C	6 Other (Specify) 28d. DESCRIBE HOW IN 28f. LOCATION (Street e City or Town, State) a to the cause(a) and man o time, data and place, and	nd Numbe	r or Rural Ro Red, he cause(a)	and manner as stated.
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-to-be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,



BALLIMORE, MANTLAND ZIZIS-0020	s after death. Page 6 may be retained by the hospital or attending physician.	i by the funeral director, page 5 should be detached for use as the burial-transit permit removal.
	non	lled in
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2. Nours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

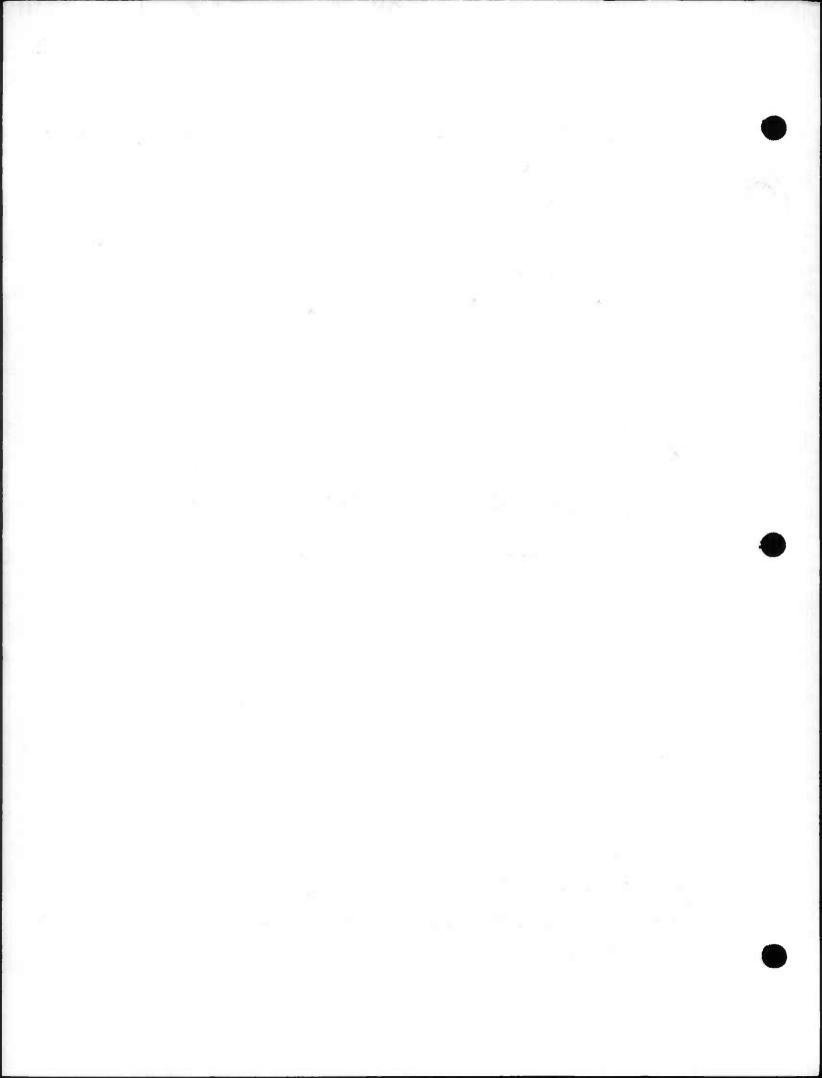
FOR 1 STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR			SNIJEL	CALE	F DEATH	F	EG. NO.		
1	1. DECEDENT'S NAME (First, Middle, Last)	. 7					2. DATE OF	DEATH DAY	YEAR	3. TIME OF DEATH
	DONALD KA	Y BRO	WN				02	0 6		0800 11
10	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. les	t birthday)	IF UNDER I YEA		7. DATE OF I		8. BIRT	HPLACE (State or Foreign
3	219-20-0745	1 M 2 □ F	68	YRS.	MONTHS DAY	B HOURS MIN.	July	1,1920	6 Mar	yland
	9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE									7
OR	8820 Biggs For	Wal	kersville			Fred	erick			
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d INSIDE CITY									
DIRECTOR										10d. INSIDE CITY LIMITS?
	Maryland	Frederick			Walker	lalkersville				1 YES 2 NO
3A	10e. STREET AND NUMBER					101, ZIP CODE				WHAT COUNTRY?
FUNERAL	8820 Biggs For					21793				d States
5	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EV FORCES? 1			13. WAS I	DECENDENT OF HISPAN specify Cuban, Mexica	NIC ORIGIN? (S	pecify Yes or	No — 14. RAC	CE — American Indian, ck, White, atc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR OATES			rES 2 NO Specify		,, 2,	Spe	cify;
	15. DECEDENT'S EDUC			CEDENT'S I	JSUAL OCCUPA					White
COMPLETED	(Specify only highest grade	completed)	(Gi	ive kind of w	ork done during retired.)	most of working	16b. KJN	ID OF BUSIN	ESS/INDUSTRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5+)	10000		chanic		Δ11.	to Car	raco /M	echanic
M	17. FATHER'S NAME (First, Middle, Last)		210	eo ne	Chanic	18. MOTHER'S NA	_			echanic
	The second secon	rles	S.	Rr	ดพาก	Mollie Mollie		e, Meiden Sui	rname)	Beard
B	19a. INFORMANT'S NAME (Type/Print)	1105				et and Number or Rural I				Deard
2	Ethel E. Brown					Ford Rd./				21702
	20a, METHOD OF DISPOSITION				FDISPOSITION				TION — City or T	
	1 Buriel 2 Cremation 3 Remo	oval from State			I Ceme		1			Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	110010	, 1111				C.C.	50010,	rialyland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Stauffer Fu 40 Fulton Ave./ Walkersvil										1 Home
	23. PART A britar the diseases, or control of head falling	reers	on		,					d. 21/93
	IMMEDIATE CAUSE (Final	ARTERIO	on eech line	er oti	ic CA					Approximate Interval Between Onset and Death
1	1	DOL TO (OR		,						1 1
TION	Sequentially list conditions, if any, leeding to immediate	o	AS A CONSEC	DUENCE OF	:					
CATION	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	OUE TO (OR	AS A CONSEC							
TIFICATION	If any, leeding to Immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events	OUE TO (OR								
CERTIFICATION	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	OUE TO (OR	AS A CONSEC							
AL CERTIFICATION	If any, leeding to Immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events	OUE TO (OR	AS A CONSEC	DUENCE OF	:	ring cause given in	Part i. 24s	I. WAS AN AU		b. WERE AUTOPSY FINDINGS
ICAL CERTIFICATION	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	OUE TO (OR	AS A CONSEC	DUENCE OF	:	ring cause given in		PERFORME	D?	AMAILABLE PRIOR TO COMPLETION OF CAUSE
EDICAL	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	OUE TO (OR	AS A CONSEC	DUENCE OF	:	ring cause given in			D?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	OUE TO (OR	AS A CONSEC	DUENCE OF	:	ring cause given in		PERFORME	D?	AMAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL	if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST PART ii. Other significant condition 25. WAS CASE REFERRED TO MEDICAL	OUE TO (OR OUE TO (OR	AS A CONSEC	DUENCE OF	the underly	ring cause given in	1	PERFORME	D?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST PART II. Other significant condition	OUE TO (OR	AS A CONSEC	OUENCE OF	the underly	PLACE OF DEATH (Chi	1 [PERFORME VES 2	D?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OUE TO (OR OUE TO (OR OUE TO (OR I. HOSPITAL: 1 Inpetient 2 ER. 290. DATE OF INJI	AS A CONSECUTION OF THE PROPERTY OF THE PROPER	DUENCE OF	26 OTHER: 4 Nursing H	PLACE OF DEATH (Christone 5 Residence	eck anly one) 8 Other (Sp	PERFORME YES 2 (X	D?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICAL	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 by YES 2 \(\text{NO} \) 27. MANNER OF DEATH 1 \(\text{X} \) Netural 5 \(\text{Pending} \)	OUE TO (OR OUE TO (OR OUE TO (OR OUE TO (OR OUE TO (OR OUE TO (OR OUE TO (OR	AS A CONSECUTION OF THE PROPERTY OF THE PROPER	DUENCE OF	28. OTHER:	PLACE OF DEATH (Chi	eck anly one) 8 Other (Sp	PERFORME YES 2 (X	NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
BY PHYSICIAN: MEDICAL	if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 by YES 2 \(\square\$ NO 27. MANNER OF DEATH	OUE TO (OR OUE TO	AS A CONSECTION OF THE PROPERTY OF THE PROPERT	DUENCE OF	28. OTHER: 4 Nursing H OF 28c. M 1 [PLACE OF DEATH (Chi	ack only one) 8 Other (Sp 28d. DESCRIII 28f. LOCATIO	PERFORME YES 2 (Management) BE HOW INJU	NO	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 by YES 2 \(\text{NO} \) 27. MANNER OF DEATH 1 \(\text{Natural} \) 5 \(\text{Pending} \) ending investigation	OUE TO (OR OUE TO (OR OUE TO	AS A CONSECTION OF THE PROPERTY OF THE PROPERT	DUENCE OF	28. OTHER: 4 Nursing H OF 28c. M 1 [PLACE OF DEATH (Chi	ack only one) 8 Other (Sp 28d. DESCRIII 28f. LOCATIO	PERFORME YES 2 (2)	NO NO URY OCCURED	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 by YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined	OUE TO (OR OUE TO	AS A CONSECTION OF THE PROPERTY OF THE PROPERT	DUENCE OF	28COTHER: 4 Nursing H OF 28c. M 1 [reet, factory, o	PLACE OF DEATH (Cha	eck only one) 8 Other (Sp 28d. DESCRIII 281. LOCATIO City or 70	PERFORME YES 2 WES 2 WES 2 WEST 2	JRY OCCURED Number or Rural	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 by YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only)	OUE TO (OR OUE TO	AS A CONSECTION OF THE PROPERTY OF THE PROPERT	DUENCE OF	28C. OTHER: 4 Nursing H OF 28c. M 1 [reet, factory, o	PLACE OF DEATH (Chr. forme 5 Residence injury AT work? YES 2 NO	eck only one) 8 Other (Sp 28d. DESCRIII 28f. LOCATIO City or To	PERFORME YES 2 Security BE HOW INJL N (Street end wn, State)	JRY OCCURED Number or Rural	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
COMPLETED BY PHYSICIAN: MEDICAL	if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 1 Yes 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigntion 3 Suicide 8 Could not be determined 29. CERTIFIER (Check only one) 2 MEDICAL EXAMINER	OUE TO (OR OUE TO	AS A CONSECTION OF THE PROPERTY OF THE PROPERT	DUENCE OF	28C. OTHER: 4 Nursing H OF 28c. M 1 [reet, factory, o	PLACE OF DEATH (Cha	eck only one) 8 Other (Sp 28d. DE\$CRIII 28f. LOCATIO City or To to the cause(e time, date and	PERFORME YES 2 Western A State of the Control of t	JRY OCCURED Number or Rural r ee stated,	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 M YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 299-SIGNATURE AND TITLE OF CERTIFIES	OUE TO (OR OUE TO	AS A CONSECTION OF THE PROPERTY OF THE PROPERT	DUENCE OF	26. OTHER: 4 Nursing H OF 28c. RY M 1 [reet, factory, of at the time, d , in my opinion	PLACE OF DEATH (Ch. Tome 5 Residence INJURY AT WORK? YES 2 NO Hice ate end place, end due b, death occured at the	eck only one) 8 Other (Sp 28d. DESCRIII 281. LOCATIO City or 70 to the cause(e	PERFORME YES 2 WES 2 WES 2 N (Street and wn, State)	JRY OCCURED Number or Rural r ee stated. lue to the cause(ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
COMPLETED BY PHYSICIAN: MEDICAL	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 M YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 299-SIGNATURE AND TITLE OF CERTIFIES	OUE TO (OR OUE TO	AS A CONSECTION OF THE PROPERTY OF THE PROPERT	DUENCE OF	26. OTHER: 4 Nursing H OF 28c. RY M 1 [reet, factory, of at the time, d , in my opinion	PLACE OF DEATH (Ch. Tome 5 Residence INJURY AT WORK? YES 2 NO Hice ate end place, end due b, death occured at the	eck only one) 8 Other (Sp 28d. DESCRIII 281. LOCATIO City or 70 to the cause(e time, date and	PERFORME YES 2 WES 2 WES 2 N (Street and wn, State)	JRY OCCURED Number or Rural r ee stated. lue to the cause(ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 M YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 299-SIGNATURE AND TITLE OF CERTIFIES	OUE TO (OR OUE TO	AS A CONSECT AS A CONSECT With but not received a consect of the	DUENCE OF POPULATION OF THE PO	26. OTHER: 4 Nursing H OF 28c. RY M 1 [reet, factory, of at the time, d , in my opinion	PLACE OF DEATH (Ch. Tome 5 Residence INJURY AT WORK? YES 2 NO Hice ate end place, end due b, death occured at the	eck only one) 8 Other (Sp 28d. DESCRIII 281. LOCATIO City or 70 to the cause(e time, date and	PERFORME YES 2 WES 2 WES 2 N (Street and wn, State)	JRY OCCURED Number or Rural r ee stated. lue to the cause(ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 M YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 299-SIGNATURE AND TITLE OF CERTIFIES	OUE TO (OR OUE TO	AS A CONSECT AS A CONSECT With but not received a consect of the	DUENCE OF POPULATION OF THE PO	26. OTHER: 4 Nursing H OF 28c. RY M 1 [reet, factory, of at the time, d , in my opinion	PLACE OF DEATH (Ch. Tome 5 Residence INJURY AT WORK? YES 2 NO Hice ate end place, end due b, death occured at the	eck only one) 8 Other (Sp 28d. DESCRIII 281. LOCATIO City or 70 to the cause(e time, date and	PERFORME YES 2 WES 2 WES 2 N (Street and wn, State)	JRY OCCURED Number or Rural r ee stated. lue to the cause(AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,

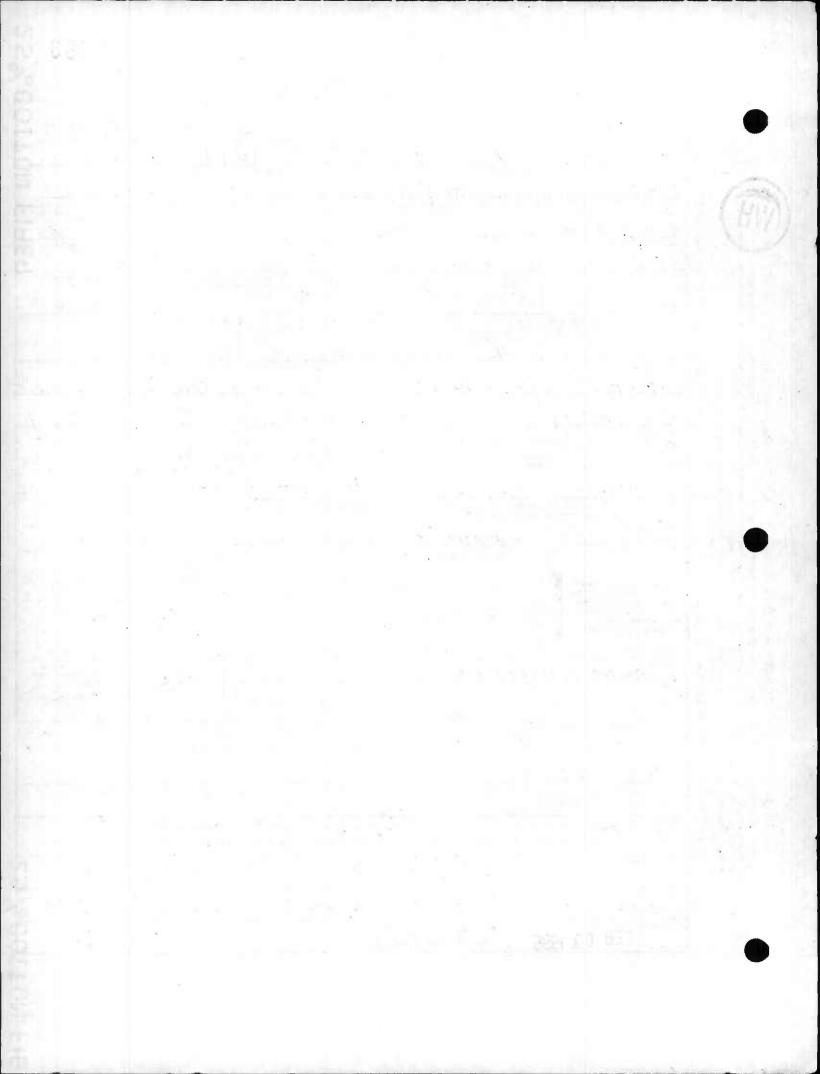
MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.



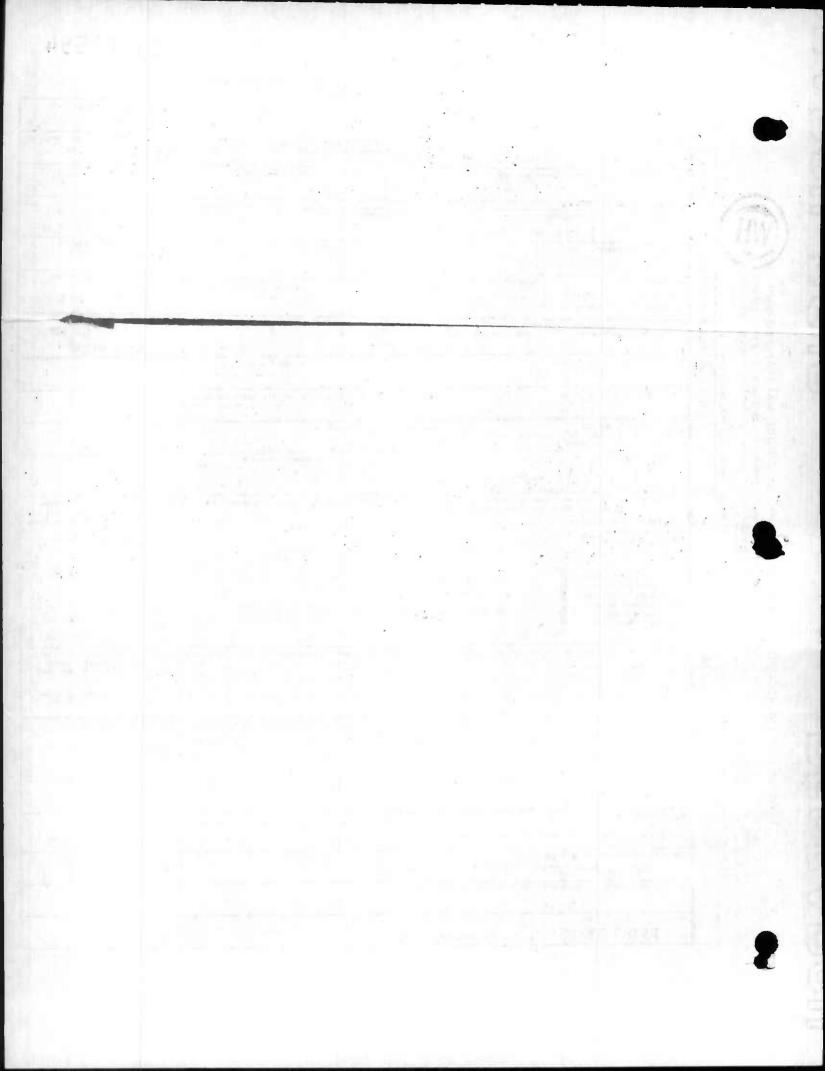
4ND 21215-0020	e hospital or attending physician.	etached for use as the burial-transition in the second second	nce.
DS, P.O. BOX 68760. BALTIMORE, MARYLAND 21215-0020	The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transmit more be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	im 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that t	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely iffled in by the te filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: It item 28 Is marked, or item 23 shows any I

	FOR 1 - STATE REGISTRAR	STATE OF MARY		IENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIENE REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH	3. TIME OF DEATH						
	Marquerite	Wilhan	ine Balo	twin	MONTH DAY	1995 4:40pm						
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AG		UNDER 1 YEAR IF UNDER 24 HRS. NTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	s. BIRTHPLACE (State or Foreign Country)						
	9e. FACILITY NAME (If not institution, give s	itreet and number)	/ 91	CITY, TOWN OR LOCATION OF E	DEATH 9c. C	COUNTY OF DEATH						
DIRECTOR	Frederick A	Memorial H	aspital I	Frederick	1	redevick						
IRE	10e. STATE 10b. COUNTY	Y	-	DWN OR LOCATION		10d. INSIDE CITY LIMITS?						
	10. STREET AND NUMBER	teack-	Fred	101. ZIP CODE	10g.	1 YES 2 NO CITIZEN OF WHAT COUNTRY?						
FUNERAL	4317 Buckeys	town Pik	0	21701		USA						
	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 NO	13. WAS DECENDENT OF HISPA If yee, specify Cuben, Mexic 1 YES 2 NO Spec		Black, White, atc.						
D BY	3 Widowed 4 Divorced					Specify: White						
ETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondery (0-12)		(Give kind of work	done during most of working	16b. KIND OF BUSINESS	/INDUSTRY						
COMPLET		4	Physical	Therapist	Medica							
	17. FATHER'S NAME (First, Middle, Last)	1 "R	and Co	18. MOTHER'S N	AME (First, Middle, Meiden Suman	70)						
BE	190. INFORMANT'S NAME (Type/Print)	4 mond D	19b. MAILING AC	ORESS (Street end Number or Rural	I Route Number, City or Town, State	hena Hainer						
입	Ellen Kartlett		4317	Buckeystown	1 tike Fred	Firt MD 21701						
	20e. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Rem. 4 Donetion 5 Other (Specify)		Ob. PLACE AND OATE OF D emetery, cremetory or other	place)	DAJES 20c. LOCATION	— City or frown, State						
	21. SIGNATURE OF PUNERAL SERVICE LIC	CENSEE	Hillcrest	22. NAME AND ADDRESS OF F	ACILITY Stauffer	Huneral Home						
	* Kaymond	Petro	on.	1121 Opossum	town Pike, Fr	ederick, MO 21702						
	23. PART I. Enter the diseeses, or a shock, or heert failure.	complications that cause or List only one cause or	ed the death. Do not each lina.	enter the mode of dying, au	ch ea cerdiec or raepiratory	Approximete						
-	IMMEDIATE CAUSE (Final disease or condition	METART	ATIC UTA	ELINE CANCE	20	Onset and Death						
	DUE TO (OR AS A CONSEQUENCE OF):											
NO	Sequentially list conditions, Due to (or as a consequence of):											
CERTIFICATION	If any, leading to Immediata cause. Enter UNDERLYING CAUSE (Disease or Injury											
	that initiated evants resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF):									
빙		d										
8 8	PART II. Other significant condition	18 contributing to death	but not resulting in t	ha underlying cause given is	PERFORMEO?	AVAILABLE PRIOR TO						
					1 TYES 2 KNO	OF DEATH?						
N.												
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 🖟 NO	HOSPITAL:		26. PLACE OF DEATH (C								
PHYSICIAN: MEDIC	27. MANNER OF OEATH	28e. OATE OF INJUR (Month, Day, Year	Y 28b. TIME O		28d. OESCRIBE HOW INJURY	OCCURED						
BY	1 Natural 5 Pending 2 Accident Investigation			M 1 YES 2 NO								
ם	3 Suicida 6 Could not be determined	building, atc. (S	RY — At homa, farm, atre- pecify)	et, rectory, office	28f. LOCATION (Street and Nur City or Town, Stafe)	mber or Rural Route Number,						
PLE	29a. CERTIFIER 1 CERTIFYING PHYSI	ICIAN: To the beat of my kn	owledge, death occurred a	t the time, date end place, and du	e to the cause(a) and menner ee	atated.						
COMPLETED						to the ceuse(e) and menner ee stated.						
BE	296. SIGNATURE AND TITLE OF CERTIFIES	Fron Cy	Kons	29c. LICENSE NU	JMBER 29d.	OATE SIGNED (Moght, Day, Year)						
٩	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF	DEATH (ITEM 27) (Type, Pri	SELLENT OF	CAGNER	MD 21701						
	31. DATE FILED (Month, Day, Year)			SEVENTH ST	FREDERICK	,						
	FEB 01 199	5 Jalia da	SNATURE PROBLEM									



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

FOR

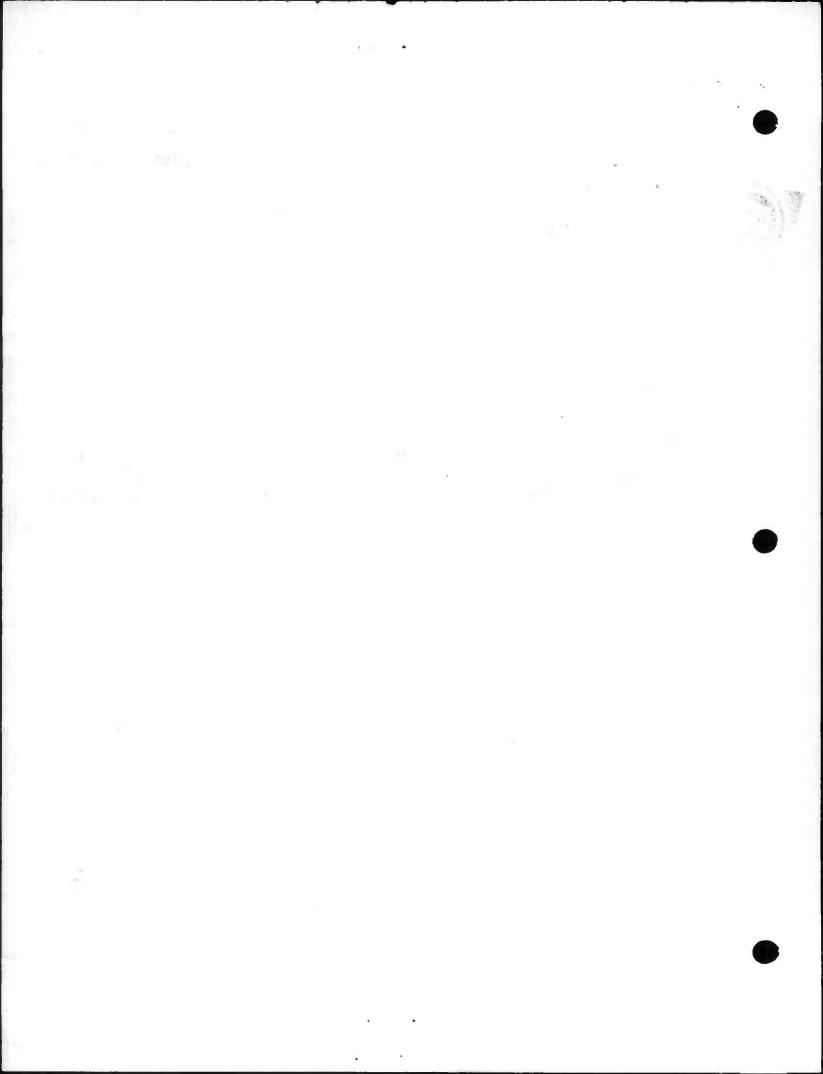


DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache		IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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	in by	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	edica	
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL CERTIFICATE OF DEATH	REG. NO.
	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL CERTIFICATE OF DEATH

	1 - STATE REGISTRAR	C			F DEATH		i. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)				-	2. DATE OF DEA	ATH		3. TIME OF DEATH	
- 7	TILTON	EARES				MONTH 1	28	1995	11:30 p M	
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. le:	st birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF BIRT			HPLACE (State or Foreign	
	212-03-1684 1XX M 2 🗆	F 90	YRS.	MONTHS DAY	HOURS MIN.	Mar.15		Coun	(Y)	
	9e. FACILITY NAME (If not institution, give street and number			9h CITY TOW	N OR LOCATION OF DE			COUNTY OF	timore,Md.	
E C	GREATER BALTIMORE MEDICA					-AITI				
DIRECTOR	RESIDENCE OF DECEDENT	L CENTER		10	WSON			BALTIM	ORE	
#	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LO	CATION				10d. INSIDE CITY LIMITS?	
ā	Maryland Baltimore			Fork					1 - YES 2 1 NO	
AL	10e. STREET AND NUMBER				101. ZIP CODE		101		WHAT COUNTRY?	
FUNERAL	12528 Harford Road			21051			U.	S.A.		
5		DENT EVER IN U.S. AF	RMED		ECENDENT OF HISPAN			14. RAC	E — American Indian, k, White, etc.	
1 Never Merried 2 X Married 1 Never Merried 2 X Married 1 VES 2 X NO 1 YES 2 X NO 1 YES 2 X NO 1 YES 2 X NO 1 YES 2 X NO 2 Specify:								WHI		
				<u> </u>					IE	
H	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(G	ECEDENT'S Sive kind of a b. Do NOT us	VSUAL OCCUP	TION most of working	16b. KIND (OF BUSINES	SS/INDUSTRY	8345	
ا ڐ	Elementary/Secondary (0-12) College (1-4 of 100 days		Man	faat						
COMPLETED	17, FATHER'S NAME (First, Middle, Last)	1110	achin	120	40 11001110010 111			uring		
8	Samuel Beares					ME (First, Middle, A				
10 INCOMANTS NAME (Total Color)										
2	Mr. Albert Barnhart							m, Md.2	1057	
20b. PLACE AND DATE OF DISPOSITION DATE 20c. LOCATION — CIN.										
ATBurlel 2 Cremation 3 Removal from State Carmetery, crematipry or other (place) 4 Donetion 5 Other (Specify) Fork, Maryle										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		ï	22. NAME	AND ADDRESS OF FA	CILITY			y I dild	
	E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Md. 2108									
\dashv	23. PART I. Enter the diseeses, or complications		ooth Do	117	'50 Belair	Road K	<u>ingsv</u>	ville.M		
	ahock, or heart fallure. List only one	cause on each line	8.	iot enter the	node of dying, suc	n es cardiac or	respirato	ry arrest,	Approximate Interval Between	
	IMMEDIATE CAUSE (Finel disease or condition	-0							Onset and Death	
1	resulting in deeth) e	TO (OR AS A CONSE	OHENCE OF							
	_	TO (ON AS A CONSE	OUENCE O	7):					i ;	
CERTIFICATION	Sequentielly list conditions, b.	TO (OR AS A CONSE	OUENCE O	ř):						
Ä	If sny, leeding to immediate ceuse. Enter UNDERLYING								İ	
E	CAUSE (Diseese or Injury thet initieted events	TO (OR AS A CONSE	OUENCE OF	F):						
F	resulting in desth) LAST									
	PART II. Other significent conditions contributing	to death but not	en estable es	in Alba constant	lan construct to	5-41 L				
DICAL	A	to death but not i	resulting	n the underly	ing ceuse given in	PI	AS AN AUTO	?	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
Ē	anentra -					1 🗆 Y	ES 2 🖽	10	OF DEATH?	
≥	DID TOPACCO LICE CONTRIBUTE TO	CAUCE OF DEA	T11 1/5	·		-			1 TYES 2 NO	
AN	DID TOBACCO USE CONTRIBUTE TO 25. WAS CASE REFERRED TO MEDICAL			H (Check only o		11				
2	EXAMINER? HOSPITAL			OTHER:						
PHYSICIAN:		OF INJURY	28b. TIM		nme 5 Realdence	8 Other (Specification 28d, DESCRIBE I		V OCCUPED		
	1 Natural 5 Pending (Mont	h, Day, Year)		URY	WORK?	200. DESCRIBE	1011 INJUN	OCCORED		
B	2 Accident Investigation 3 Suicide 8 Could not be 28e. PLAC	E OF INJURY — At ho	ome, farm, s			281. LOCATION (S	Street and M	humber or Qual	Coude Mumber	
	4 Homicide 8 Could not be build	ng, etc. (Specify)	,	,,	,,,,,	City or Yown,	State)	umber or nurer	Notice Number,	
COMPLETED	29a, CERTIFIER									
MP	(Check only One) 2 MEDICAL EXAMINED: On the beat									
8	2 MEDICAL EXAMINER: On the basis	or exemination end/or	Investigatio	n, in my opinior	, death occured at the	lime, date and pla	ce, and du	s to the couse(a) and manner ea stated.	
BE	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM	IBER	29d	. DATE SIGNED	(Month, Day, Year)	
2	20 NAME AND ADDRESS OF TAXABLE MAIN				1 1/4	1104		1 2	0 42	
-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED	AUSE OF DEATH (ITE		Print)	10.14		an	2176	U	
	10110	TRAR'S SIGNATURE	10	14	- Davin	rere 1	VV	2166		
		THAR'S SIGNATURE	1							
- 11	FER T 9 1932		- The same of							



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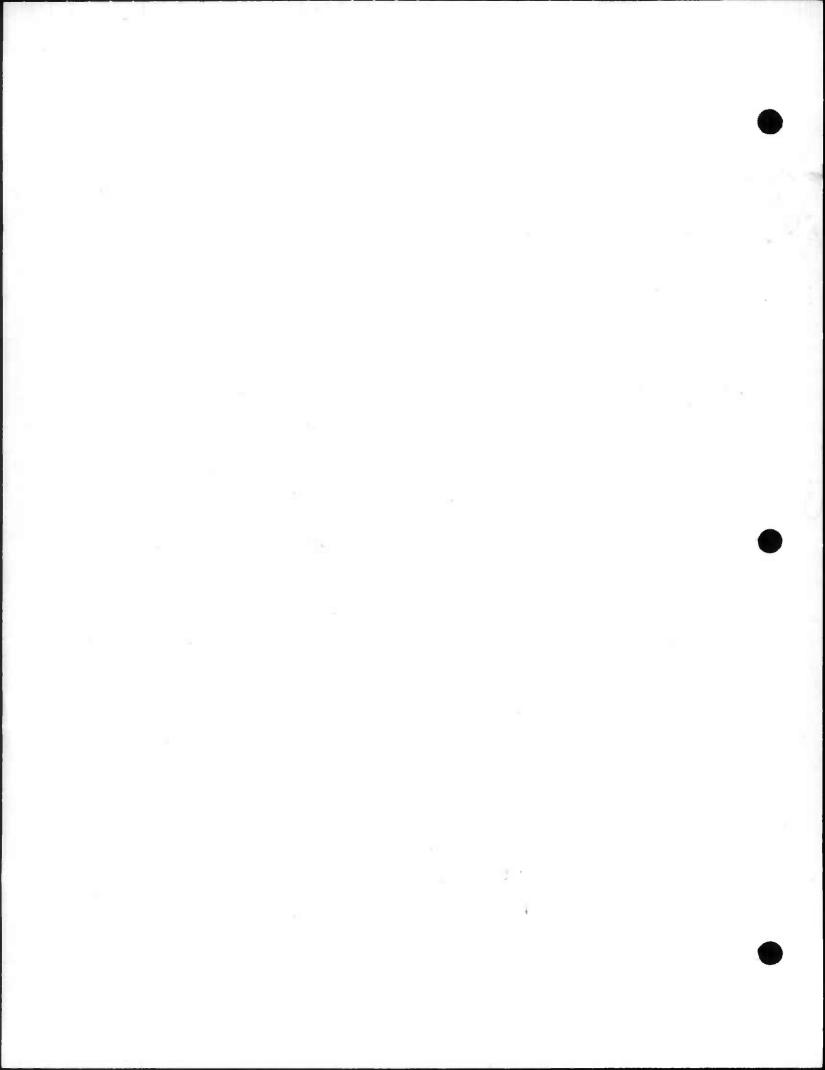
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

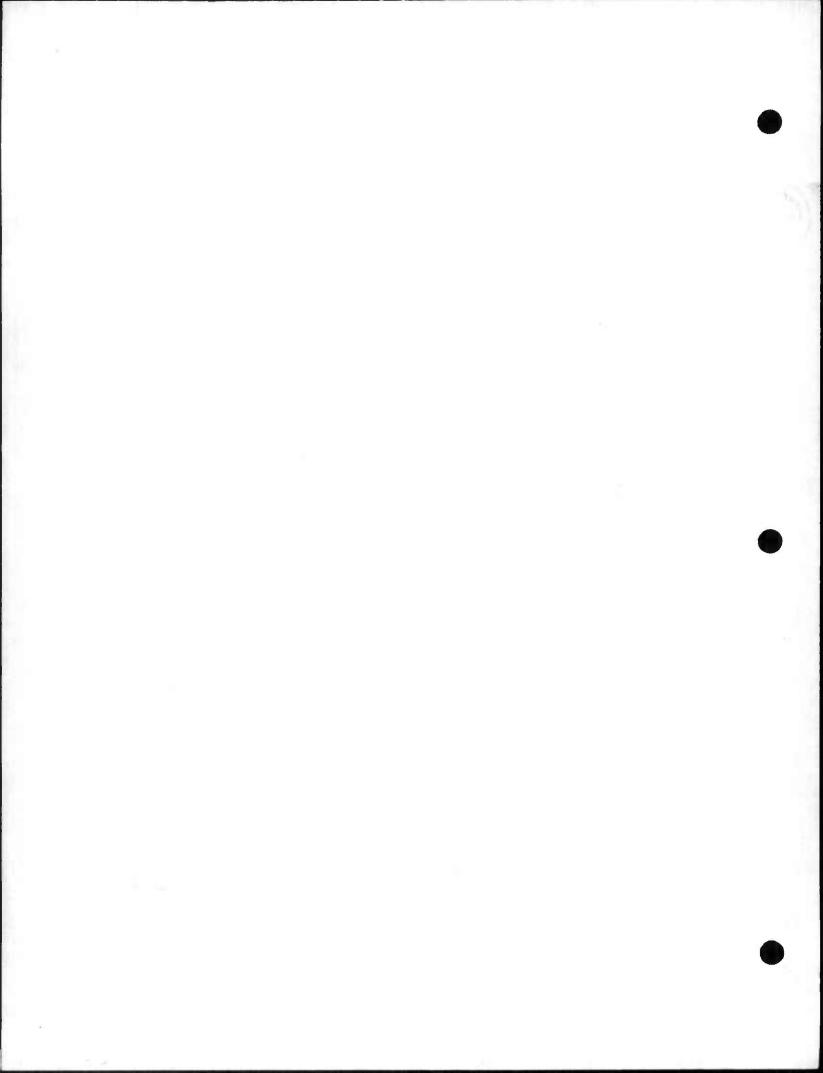
REG NO.

	TIEGIOTTIAIT				CHIII	CAIL	. OF	DEAL	п		REG. NO.			
	1. DECEDENT'S NAME (First,									2. DATE OF MONTH	DEATH	w	YEAR	3. TIME OF DEATH
	Bernice Ma	deline	Beavers	5						Janua			95	9:45 PM
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs. les	at birthday)	IF UNDER		IF UNDER		7. DATE OF	ВІЯТН		6. BIRTH	PLACE (State or Foreign
	577-24-4187	7	1 🗌 M 2 🔀 F	82	YRS.	MONTHS	DAYS	HOURS	MIN.	July	26,	1912	Country	y) -1 3
	9a. FACILITY NAME (If not in		9b. CITY,	TOWN C	OR LOCATIO	N OF DE	ATH		9c. COU	Mary OF D	Land			
۳.	3713 Decatur Avenue						% CITY, TOWN OR LOCATION OF DEATH Kensington				Montgomery			
8	RESIDENCE OF DEC	EDENT	140			Rensington Mon				Mont	-gome	ery		
DIRECTOR	10a. STATE 10b. COUNTY 10c.					Y, TOWN OR LOCATION 10d. INSIDE					10d. INSIDE CITY			
ā	Maryland	Montq	omery		K.	ensin	ato	n						LIMITS?
AL	10a. STREET AND NUMBER					2110211		. ZIP CODE				10g. CITI	ZEN OF W	/HAT COUNTRY?
FUNERAL	3713 Decatu	r Aven	110					2089	-					
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. AF	MED	13. W	AS DEC			IC ORIGIN? (Specify Yea	or No-	14. RACE	- American Indian,
	1 XXNever Married 2		FORCES? 1	YES 2 XI	NO	1 10	yes, sp	ecify Cuban 2XXNO	i, Maxicar	n, Puerto Rica	en, atc.)		Black	, White, etc.
BY	3 Wildowed 4 Divo	roed				1.	_ 123	21210	эрвину				Specif	hite
COMPLETED	15. DEC	EDENT'S EDUC	ATION	16a. DE	CEDENT'S	USUAL OC	CUPATIO	ON .		18b. KI	ND OF BUS	INESS/IND	USTRY	
	Elamentary/Secondary (0		College (1-4 or 5 d	-) (G	. Do NOT us	vonk done di se retired.)	unng mo	st of working	7					
4	12				edit	Inve	stic	ator		Cr	edit	Buro	211	
ő	17. FATHER'S NAME (First, Mi	iddle, Last)											au	
17. FATHER'S NAME (First, Middle, Last) George T. Beavers Bessie Selby														
M SO INFORMATIC NAME (To CAR)														
Betsy M. Snyder 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4011 Robert Ruark Drive, Southport, N.C. 2									00464					
	20a. METNOD OF DISPOSITI	ON		20h PLACE	ANDDATE	SE DIEDOEL	TION (AID	mant 2	1210	E DATE	200 100	MONTA	014 T-	
	1X XBuriel 2 Cremation 4 Docation 5 Dother		rvel from State	cemetery, cre	metory or o	ther place)	Mot	·hodii	72/9	S DAIL		Allon -	only of To	ryland
į	21. SIGNATURE OF FUNERAL		ENGEE	- P O COM	ac on	1 22. N	AME AN	D ADDRES	S OF FAC	em.	Pot	omac	, Ma	ryland rey Funeral
ŀ	-1	10	D			Hor	ne/F	lockv:	ille	. Inc	. 300	Wes	t Mo	ntgomery
	/ Chie	15	leme	. MC	00803	AVE	enue	, Ro	ckvi	lle, l	Marvl	and	208	50-2805
ı	23. PART i. Enter the di	seesea, or co	ompiications that ist only one ceu	caused the de	ath. Do r	ot enter 1	the mo	da of dyir	ig, such	as cardisc	or reapi	ratory arr	eat,	Approximate
	IMMEDIATE CAUSE (Fin							0 \						interval Between Onset and Death
ŀ	disesse or condition resulting in desth)	→ .	a	Her	205	الم	10	the	1	Ja an	+	De	9-9	
ĺ	roaditing in additing		DUE TO	(OR AS A CONSE	QUENCE OF	j:							3-64. 2	
z			i.											
CERTIFICATION	Sequentisity list conditi if any, leeding to immed	ons, diete	DUE TO	OR AS A CONSE	QUENCE OF	7):								
2	cause. Enter UNDERLYii CAUSE (Disesse or inju-													
E	that initiated events		DUE TO	OR AS A CONSE	QUENCE OF	7):								
E	resulting in death) LAS													
	PART ii. Other significe	nt conditions	contributing to	dooth but not -	and the state of	- 44	to all date							
EDICAL	<u> </u>	TO CONTRICTION	contributing to	death but not i	esuring i	n the unc	eriying	ceuse gi	iven in i	Part I. 24	PERFOR		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ă										_ 1	YES 2	€XN0		COMPLETION DF CAUSE OF DEATH?
ΣI										_				1 TES 2 NO
ž I	DID TOBACCO US	SE CONTR	IBUTE TO CA	USE OF DEA	TH YE	S N	10 🗆	UNCE	RTAIN					
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	1000	HOSPITAL:	26. PLAC	E OF DEAT	N (Check of								
YS!	1 X YES 2 NO		1 Inpatient 2	ER/Outpatient 3	□ DOA	OTHER:		5 X Res	Idenca	B Other (S)	pecify)			
E I	27. MANNER OF DEATN		28e. DATE OF (Month, Di	INJURY IV. Year)	28b. TIMI	E OF 2	28c. INJU	JRY AT		28d. DESCR	BE NOW IN	JURY OCC	URED	
B		Pending nvestigation	This con	,,		M		ES 2 🗌	NO					
	3 Suicide 8 (Could not be	28a. PLACE Of building.	F INJURY — At ho	me, farm, s	treet, factor	ry, office	,		281. LOCATIO	ON (Street a	nd Number	or Rural Ad	oute Number,
	4 Nomicide c			area (opcomy)						City or it	own, State)			
# 17		letermined												
~ 11	AL APPRICE		IAN: To the best of	my knowiedne de	ath occurs	d at the tim	no dete	and alone	and due i	a the sevent				
MP	29a. CERTIFIER (Check only	IFYING PNYSIC	IAN: To the best of											
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTI	FYING PNYSIC						eath occure	d at the t	lime, date and				and manner on stated.
BE COMPI	29a. CERTIFIER (Check only	FYING PNYSIC	: On the basis of ax	tamination and/or i				29c. LICEN	d at the I	BER	I place, and	due to the	cause(s)	and manner ea stated. (Month, Day, Year)
8	29a. CERTIFIER (Check only one) 2 MEDIC 29b. SIGNATURE AND TITLE	CAL EXAMINER	: On the basis of ax	Camination and/or I	investigation	п, Іп ту ор		29c. LICEN	d at the I	lime, date and	I place, and	29d. DATE	SIGNED	
шШ	29a. CERTIFIER (Check only one) 1 CERTI 2 MEDI 29b. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF	FYING PNYSIC CAL EXAMINER OF CERTIFIER PERSON WNO	COMPLETED CAUS	E OF DEATH (ITE	M 27) (Type,	n, In my op	Inlon, de	29c. LICEN	d at the l	BER	i place, and	29d. DATE	SIGNED	(Month, Day, Year)
8	29a. CERTIFIER (Check only one) 2 1 CERTI (Check only one) 2 1 MEDIC 2 1 MED	OF CERTIFIER PERSON WNO	COMPLETED CAUS	E OF DEATH (ITER	M 27) (Type,	n, In my op	Inlon, de	29c. LICEN	d at the l	BER	i place, and	29d. DATE	SIGNED	(Month, Day, Year)
8	29a. CERTIFIER (Check only one) 2 1 CERTI (Check only one) 2 1 MEDIC 2 1 MED	OF CERTIFIER PERSON WNO uber,	COMPLETED CAUSE M. D. 82	e of DEATH (ITE) 18 Wisco	M 27) (Type,	n, In my op	Inlon, de	29c. LICEN	d at the l	BER	i place, and	29d. DATE	s cause(s) SIGNED	(Month, Day, Year)
8	29a. CERTIFIER (Check only one) 2 1 CERTI (Check only one) 2 1 MEDIC 2 1 MED	OF CERTIFIER PERSON WNO	COMPLETED CAUS	e of DEATH (ITE) 18 Wisco	M 27) (Type,	n, In my op	Inlon, de	29c. LICEN	d at the l	BER	i place, and	29d. DATE	s cause(s) SIGNED	(Month, Day, Year)



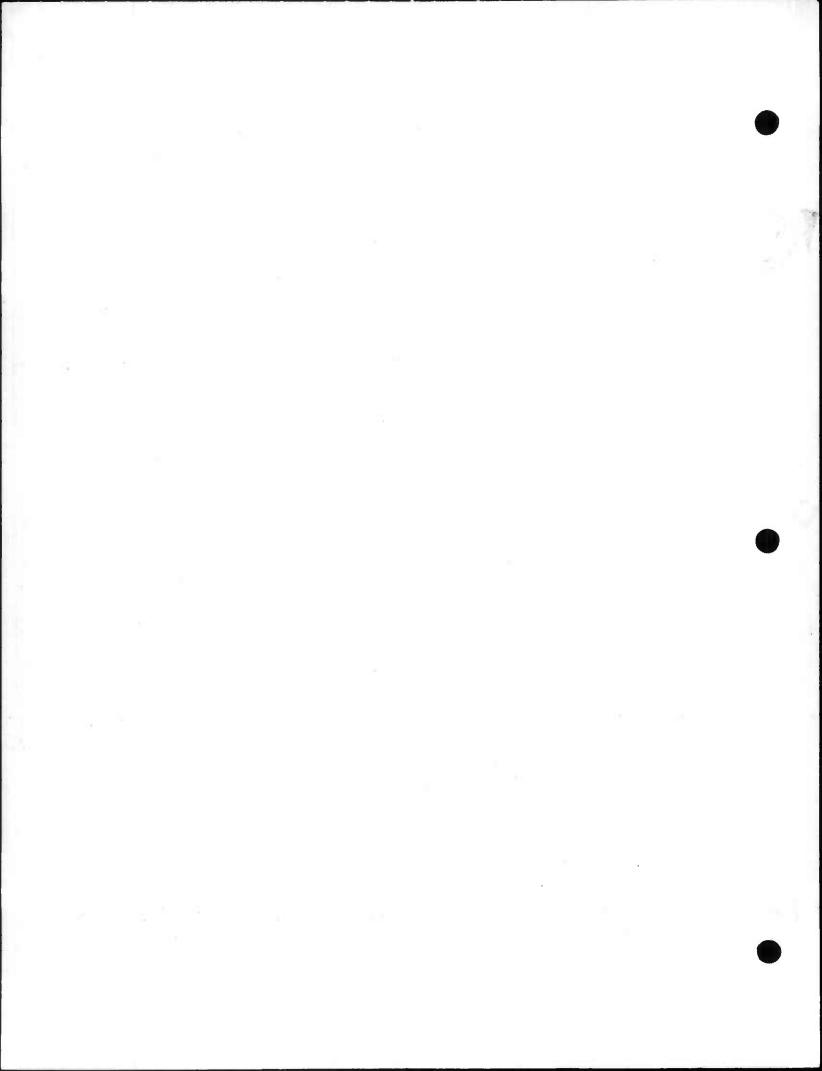
, P.O. BO	e death certificate b the attending physici Mental Hygiene priori lury, or other tra	CERTIFICA	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. Acite Ko oue to lon as a conses a. Metasta t	ual Fa	2		
RECORDS,	ires that the signed by the Health and ws any in	MEDICAL (PART II. Other algorificant condition	Cardiac	Fan E	10		
			DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF DEA	TH YES 🗆	N		
A	a ha	🕺	25. WAS CASE REFERRED TO MEDICAL	26. PLAC	E OF DEATH (Check	or		
VITAL	iCIAN: The certificate h the State I or item	PHYSICIAN:	EXAMINER?	HOSPITAL: 1 Propertient 2 ER/Outpetient 3	DOA 4 Nur			
NOF	PHY with with	If item 28 is mark		1 Pending		28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	2
DIVISION	TTENDI TOR: A after d		3 Suicide 8 Could not be detarmined	26a. PLACE OF INJURY — Al ho building, etc. (Specify)	me, farm, street, fact	101		
	国立なる		one)	CIAN: To the best of my knowledge, de R: On the basis of examination and/or i				
	TO THE HOSPI TO THE FUNER be filed within IMPORTANT:	TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	1 Vull	1	1		
		-	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DEATH (ITE	# 27) (Type, Print)	П		
			DR. CHUIAM D.	1 1510 VE.	1	1		

	HEGISTRAR			U	ERIIF	ICALE	OF DE	:AIH	R	EG. NO.			
	1. DECEDENT'S NAME (First,		Р.		Bei	redi	+		2. DATE OF I	DI	°26,	1995	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMB	ER :	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER 1 Y		NDER 24 HRS.	7. DATE OF E	HRTH	1	8. BIRTHP	LACE (State or Foreign
	156-03-3724		1 X XM 2 □ F	89	YRS.	MONTHS	AYS HOL	RS MIN.	May 3		905	New Y	Jersey
	9a. FACILITY NAME (If not ins	titution, give stree	et and number)			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE							
OH	Washington Adventist Hospital					Tak	oma P	ark			Mon	taome	art
DIRECTOR	RESIDENCE OF DECEDENT					Y, TOWN OR							
E	Maryland		George	10	1								10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	1111100	ocorge	5		Belts	10f. ZIP						YES XX NO
IRA	11605 34th F	Place						705					states
FUNERAL	11. MARITAL STATUS	1	2. WAS DECEDEN	T EVER IN U.S. AR	MED	13. WA			HC ORIGIN? (S	saalfu Maa			
	1 Never Married 2 XX	Married	FORCES? 1 IF YES, GIYE W	YES 2 V		If y	a, specify (Cuban, Mexica	n, Puerto Ricen	, etc.)	or No-		– American Indian, White, atc.
B	3 Widowed 4 Divor	ced		THE OTHER		1	YES XX	NO Specin	/:			Specify	White
COMPLETED		DENT'S EDUCAT		16a. DE	CEDENT'S	USUAL OCCL	PATION	nddaa	16b. KIN	D OF BUS	INESS/INC	DUSTRY	
9	Elementary/Secondary (0-	12)	College (1-4 or 5 +) //fe.	Do NOT us	e retired.)		orang					
M	12			Ban	ker					ivat			
	17. FATHER'S NAME (First, Mic Henry DeBe	nedict:	ic						ME (First, Middle		Surname)		
BE	19a. INFORMANT'S NAME (%)		12					lorenc					
5	Evelyn V. E		t	190	same	as #1	. O	mber or Rumil F	Route Number, C	ity or Town	n, State, Zip	Code)	
	20s. METHOD OF DISPOSITION Surini 2 Cremation 4 Donation 5 Other		al from Stala	20b. PLACE A camatery, crei	matory or o	har nlace)			DATE	20c. LO	CATION —	Cify or Tow	n, Slete
	21. SIGNATURE OF FUNERAL	THE RESERVE AND ADDRESS OF THE PERSON.		Meadowr	idge 1	Amoria		Jan.3		_Balt	imore	, Mary	rland
	-10 01	\ \		V .		Dona Dona	1d V	Borg	wardt	Fune	ra1	Home	DΛ
	Sough	- V. B	Maria	- blo		4400	Powe	der Mi	11 Rd.	Be1	tsvi	11e.	Md. 20705
	23. PART i. Enter the dis shock, or ha	seases, or cor	nplicationa that	caused the de	ath. Do r	ot enter th	moda of	dying, auci	h as cardiac	or reapli	ratory arr	eat,	Approximate
	iMMEDIATE CAUSE (Fine disease or condition resulting in death)		Card	iopula	con	ary	Av	ven	1				interval Between Onset and Death
_			DOE TO	OR AS A CONSEC	DUENCE OF	7: /	SOIL	200 1	tuda	10	000	onda	
CERTIFICATION	Sequentially list condition		DUE TO	OR AS WCONSED	WENCE OF	1	den	26 7	TELLER	u	enl	A	7 2.6KS
S	if any, leading to immed cause. Enter UNDERLYIN	IG I	Acu	to Ray	ugl	Fair	010	pone	Soh	TIE	Sup	prent	97
Ė	CAUSE (Disease or injur that initiated events		DUE TO	OR AS A CONSEC	HENCE OF	1	47		1	12	7	- week	MEDITEC
EH	resulting in death) LAST		mel	astat	c	Cou	8C1	uon	9	NO8	lat	e	
	PART ii. Other algnifican	t conditions	contributing to	death but not re	eaulting I	n the unde	iving cau	se given in	Part I 24a	WAS AN	MITTOREY	1 245 1	EDE AUTOROV EMPINOS
EDICAL	Congo	1:40	Cr-VI	Lice	En	Pi	20	ou given in		PERFOR	MED?		VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE
		4 7 4	Care	Mac.	Fa	1141		1	_ 10	YES 2	NO		F DEATH?
Σ.	DID TOBACCO US	E CONTRI	BLITE TO CAL	ISE OF DEAT	TH VE	s IT NO	NV II	NCERTAIN				1	HO P NO
¥	25. WAS CASE REFERRED TO		JOIL TO CA			H (Check only		NCERIAIN	4 L				
PHYSICIAN:	EXAMINER?		OSPITAL:	ER/Outpatient 3	DOA	OTHER:	Home &	Postdones	6 Other (Spe	-46.1			
主	27. MANNER OF DEATH		28a. DATE OF	INJURY	28b. TIM	OF 28	INJURY A		28d. DESCRIB		JURY OCC	UREO	
BYF	1 Accident 5 P	ending eventigation	(Month, Da	y, rear)	INJ		WORK?	2N NO					
	3 Suitolde 8 C	ould not be	26a. PLACE OF	INJURY - Al hor	ne, farm, a	treet, factory,	office		28f. LOCATION	(Street a	nd Number	or Rural Roo	rte Number,
	4 Hernicide d	etermined	15.111.100.00	(0)0000)					City or Tow	m, State)			
mi 11											0100		
ᆲ	29a. CERTIFIER (Check only	FYING PHYSICIA	N: To the best of	my knowledge, des	ith occurre	d at the time,	data and p	lace, and due	IO Ine cause(s)	and mani	ter as state	IPCE.	
OMPL	(Check only			my knowledge, des emination and/or is									nd manner as stated.
E COMPLETED	(Check only	AL EXAMINER:					on, death o		lime, data and (dua to the	a cause(a) s	
BE	(Check only one) 2 MEDIC	AL EXAMINER:					on, death o	ccured at the	lime, data and (dua to the	a cause(a) s	tonth, Day, Year)
	(Check only one) 2 MEDIC	OF CERTIFIER	On the basis of ax	Mull	nvestigation	n, in my opini	on, death o	ccured at the	lime, data and (dua to the	a cause(a) s	
BE	(Check only 2 MEDIC 29b. SIGNATURE AND TITLE CO. 30. NAME AND ADDRESS OF The Control of the Co	PERSON WHO C	On the basis of ax	Mull	nvestigation	n, in my opini	on, death o	LICENSE NUM 22	lime, data and (dua to the	a cause(a) s	
BE	(Check only 1 MCERTIN One) 2 MEDIC 29b. SIGNATURE AND TITLE C	PERSON WHO C	On the basis of ax	E OF DEATH (ITEM 2'S SIGNATURE	1 27) (Type,	n, in my opini	29c.	LICENSE NUM 22	lime, data and (dua to the	a cause(a) s	
踞	(Check only 2 MEDIC 29b. SIGNATURE AND TITLE CO. 30. NAME AND ADDRESS OF The Control of the Co	PERSON WHO C	On the basis of ax	Mull	1 27) (Type,	n, in my opini	29c.	LICENSE NUM 22	lime, data and (dua to the	a cause(a) s	



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		FOR 1 - STATE REGISTRAR		STATE OF I	MARYLAND C	/ DEPAI	RTMENT ICATE	OF H	IEALTH DE A	AND I		YGIEN			
		1. OECEDENT'S NAME (First BRADLE	y ·	TODO	BE	RKE	BI	45	-		2. DATE OF D MONTH	EATN DA		YEAR	
		4. SOCIAL SECURITY NUMBER 202 60 2455	5	5. SEX 1 2 M 2 F	6. AGE (In yrs. le 25	YRS.	IF UNDER	DAYS	HOURS	MIN.	7. DATE OF B. (Month, Day Feb.	Year)	1969	Countr	IPLACE (State or Foreign y) nstown, PA
18	5	9a. FACILITY NAME (If not in Suburban Ho	ospita						esda	ION OF DE	ATN			tgom	
5	DINECION	RESIDENCE OF DEC	10b. COUNT	γ		10c. CIT	Y, TOWN O						PION	Lyoni	10d. INSIDE CITY
		Maryland	Mon	tgomery			Rockv:								LIMITS?
	MAL	10e. STREET AND NUMBER		21 1100=				101	. ZIP COD				10g. CIT	IZEN OF W	VHAT COUNTRY?
	JNE	5605 Alderk	orook (12. WAS DECEDEN	T EVER IN U.S. A	BMED	112 W	MS DEC	2085		NC OBIOINS (C-	- M- M-		S.A.	
1	5	1 Never Married 2 3 Divo		FORCES? 1	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify if yes, specify Cuban, Maxican, Puerto Rican, stc.) 1 □ YES 2 疑 NO Specify:				ecity fee	or No-	E — American Indian, t, White, atc. hy: nite				
		(Specify onl	EDENT'S EOU y highest grade		(4)		Work done d			ing	16b. KINI	OF BUS	SINESS/INC	DUSTRY	
Unice.		Elementary/Secondary (0	0-12)	College (1-4 or 5	•)	_	intant				17	S	Gove	rnmor	a+
2000	5	17. FATHER'S NAME (First, M	.,,			1000	ATT COLITY	Ÿ	16. MOT	HER'S NA	ME (First, Middle				
	. 11	Glenn Ber		9							y A. Co				
		Judith Holt		Berkebile	1		abbress as]		nd Numbe	r or Rural F	Route Number, Ci	ty or Town	n, State, Zip	Code)	
negr ne		20a. METNOD OF DISPOSIT 1	ION on 3 🗆 Rem		20b. PLACE cemetery, cr	ANDDATE	OF DISPOSIT		meol		DATE		CATION —		
5		21. SIGNATURE OF FUNERA		CENSEE	2	cellet	22. N			SS OF FA				wn I	PA
- al ckell		De Day	red.	3. Ve	zuer	D	F	all	s Ch	urch	ral Sei , VA				
		23. PART I. Enter the di ahock, or hi IMMEDIATE CAUSE (Fir	eert failure.	List only one cau	ise on each iin	e.	not anter t	ine mo	de of dy	ing, suci	h aa cerdiac (or respi	ratory ari	reat,	Approximata interval Between Onset and Death
1, 110		disease or condition resulting in death)		· MUL	TIPL	F		TI	3 191	im	A				AQUTE
					(OR AS A CONSE		F):								
		Sequentially list condit		bDUE TO	(OR AS A CONSE	OUENCE O	F):								
4	5	cause. Enter UNDERLY! CAUSE (Disease or inju	ING	c											
CEPTIFICATION		that initiated events resulting in death) LAS	T .	d	(OR AS A CONSE	OUENCE O	₹} :					,			
	. 1	PART II. Other aignifice	ent condition	na contributing to	deeth but not	regulting	in the unc	feriving	COURS	alven in	Part i 24s	WAS AN	AUTOPSY	245	WERE AUTOPSY FINDINGS
MEDICAL												PERFOR	MED?	,	AVAILABLE PRIOR TO COMPLETION OF CAUSE
															OF DEATN? 1 YES 2 NO
AN.		DID TOBACCO U		RIBUTE TO CA			TH (Check or		UNC	CERTAIN	N ZZ				
DLIVEICIAN.		EXAMINER?	O MEDICAL	HOSPITAL:		-	OTHER	:	5 🗆 B	naldanca	6 Other (Spe	ciful			
770		27. MANNER OF OEATH	2722-	28a. DATE OF (Month, D	INJURY	28b. TIM		28c, INJI	JRY AT		28d. DESCRIB		UNY OC	CURED	
>	- 131	2 Accident	Pending Investigation	INVRA	426 85	1/80	18 M	1 🗌 Y	ES 2 2	NO	JUMP	ED	ON	TA	ACKS
1			Could not be determined	building,	FINJURY — At he atc. (Specify)	ome, ferm,					281. LOCATION	m, State)	nd Number	or Rural R	oute Number,
10		29e. CERTIFIER (Check only	IFYING PHYS	ICIAN: To the best of	my knowledge, d	eath occurr		ne, data	and place	and due	to the causeles		<u> </u>	1811	50 3 (H1/0 K)
POMPI ET															and manner as stated.
BE		296. SIGNATURE AND TITLE	OF CERTIFIE	01	//		1	5	29c. LIC	ENSE NUM	BER		29d. DAT	E SIGNED	(Month, Day, Year)
Ē	- 11	30. NAME/AND ADDRESS OF	F PERSON WN	O COMPLETED CAUS	SE OF MEATN (ITS	M 27) (5cc	Print		DO	70	99		JA	JURA	426 95
		FRANCIS	CM	AYLE 1	1215 K	ETINI	NOOF	A	3 %	3RT	WESD	7	MI	20	8171101
		31. DATE FILED (Month, Day,	30 199	32. REGISTRA					0 1	0.1	10				0.7.106
		JAN	<u> 199.</u>) Julia d	ander R	roball									



TO BE COMPLETED BY FUNERAL DIRECT

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

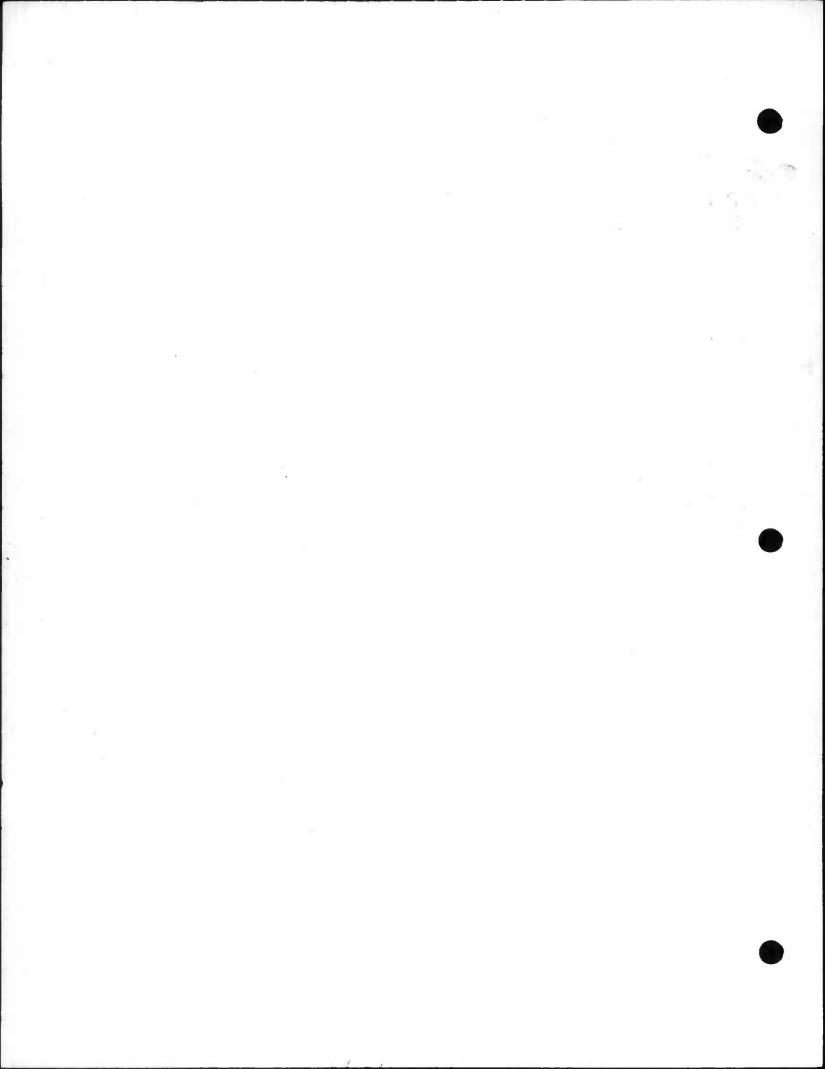
4915 Auburn
32 registraris signatura
Julia d'audion handall

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31. DATE FILED (Month, Day, Year)

1 - FOR STATE REGISTRAR		STATE OF I	MARYI	LAND /	DEPART	TMEN CAT	T OF I	HEALTH	AND	MENT	AL HYGIEN			
1. DECEDENT'S NAME (First	, Middle, Last)	-								2. DA	E OF DEATH			3. TIME OF DEATH
EaRl		5			Be	AN	de	R		Ta	YUARY 2		95	0334 AM
4. SOCIAL SECURITY NUME		5. SEX	6. AGE	(In yrs. les	" -		R 1 YEAR		R 24 HRS.	7. DAT	E OF BIRT	٠, ١٠	8. BIRTH	IPLACE (State or Foreign
215-14-71	70-A	1 [XM 2 [] F	7	2	YRS.	MONTHS	DAYS	HOURS	MIN.	Juil	nth, Day, Year)	922 Maryland		
9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF E								-4	
Shady Gro	ove A	dventis	t H	osp:	ital	Rockville Montgon							mery	
10e. STATE	10b. COUNTY	Y	_		10c. CITY	TOWN	OR LOCA	TION						10d. INSIDE CITY
Maryland	Mon-	tgomery						vil]	0					LIMITS?
10e, STREET AND NUMBER		ogocij				- 00		H. ZIP COD				10a, CIT	IZEN OF V	1 No 2 No VHAT COUNTRY?
14765 8	Sugar:	land Rd	,					208	337			1974	.S.	
11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER	IN U.S. ARI	MED	13.	. WAS DE	CENDENT	OF HISPA	NIC ORIG	IN? (Specify Yes		14. RACE	- American Indian
1 Never Married 2 3 Widowed 4 Divo	DATES	10			S 25 NO			Rican, etc.)			t, White, etc.			
2 10 17														lack
15. DECEDENT'S EDUCATION (Specify only highest grade completed) [Simulative form of the following form of th														
Elementary/Secondary (0		College (1-4 or 5	·)							Erito In Co				
17. FATHER'S NAME (First, M			COOK Frito Lay Co											
Willia	am Be	eander						1		tie				
19a. INFORMANT'S NAME (7	ype/Print) ((Grandda	uah	+ e 219)	. MAILING	ADDRES	S (Street	and Numbe	r or Rural	Route Nu	mber, City or Town	n, State, Zij	Code)	20878
Miss Cynth	nia Pi	rather	w 511	1	29 8	Sch	ool	Dr,	Ap	t#3	Gaith	ners	bur	a, Md
20a, METHOD OF DISPOSITI	ION	mel from State	20	b. PLACE A	ND DATE OF	F DISPO	SITION /N	eme of		-		CATION —		
4 Donation 5 Other	(Specify)		Cer	ST F	auI"	Ce:	met	ery		2/	1 Poo	oles	vil	le, Md
21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE		1		22.		ND ADDRE			T		D 3	20050
(10 M)	CE R	. / mi	~~	Du	_	_								. 20850 cville, Mo
23. PART I. Enter the di	seases, or c	omplications the	t cause	d the dea	ath. Do no	ot ente	r the mo	ode of dy	Ing, auc	h aa ca	rdiac or reapi	ratory an	ROCI	Approximate
IMMEDIATE CAUSE (Fin	sert fallure.	List only one ceu	se on a	ech Ilna.	5						·		=	Interval Between Onset and Death
disease or condition resulting in death)	→	. Such		ocho	CK	1	noha	11 -						12 11
		DUE TO	(OR AS	A CONSEO	UENCE OF)	13	0 00	101 E						127
Sequentially list conditi	000	DUE TO	hed	+	9 O	193	ang	re						7 days
If any, leading to immed	late	DUE TO	(OR AS	A CONSEO	UENCE OF	. 0	0					P		1
CAUSE (Diseese or Inju		oliabe	OP AS	CONSEC	LLO I	<u> </u>	pe	Mpl	wal	Merc	cularo	lusia	se	
that initiated evente resulting in death) LAS	г	30 <u>2</u> 10	1000	1 ver	a al O	1		1 49						7 mH
	-		0			000	sem							Imil
PART II. Other algnifica	nt condition	a contributing to	death t	out not re	eulting In	the u	nderlyin	g ceuse	given In	Part I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
-											1 TYES 2			COMPLETION OF CAUSE OF DEATH?
														1 _ YES 2 _ (NO
DID TOBACCO U		RIBUTE TO CA	USE C	F DEAT	TH YES		NO [UNC	ERTAI	N \square				
25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HQSPITAL:			E OF DEATH	(Check								
1 YES 2 NO		1 Inpatient 2	_	patient 3	□ DOA	4 □ Nur	rsing Hom		esidence		er (Specify)			
	Pending	28a. DATE OF (Month, D			28b. TIME INJU	OF RY	WC	PURY AT		28d. DE	SCRIBE HOW IF	JURY OC	CURED	
2 Destate	nvestigation	28a. PLACE O	F IN.RURY	- At hor	ne form etc	m	1 🔲		NO	204 1 0	CATION (C)			
	Could not be istarmined	building,	atc. (Spe	city)	ire, iaimi, est	eet, rac	tory, orne			Ch	CATION (Street a y or Town, State)	na Number	or Humi H	oute Number,
29a. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my know	ledge, das	th occurred	at the f	fime, date	end place	, and dua	to the ci	suse(a) and man	ner aa stat	ed.	
														and manner as stated.
29b. SIGNATURE AND TITLE	OF CERTIFIER							29c. LICI	ENSE NUI		· · · · · · · · · · · · · · · · · · ·			(Month, Day, Year)
KNOS	July							23	1808		4	NUAN		195

Bethesda MJ 20814



1	-	STATE REGISTRAR
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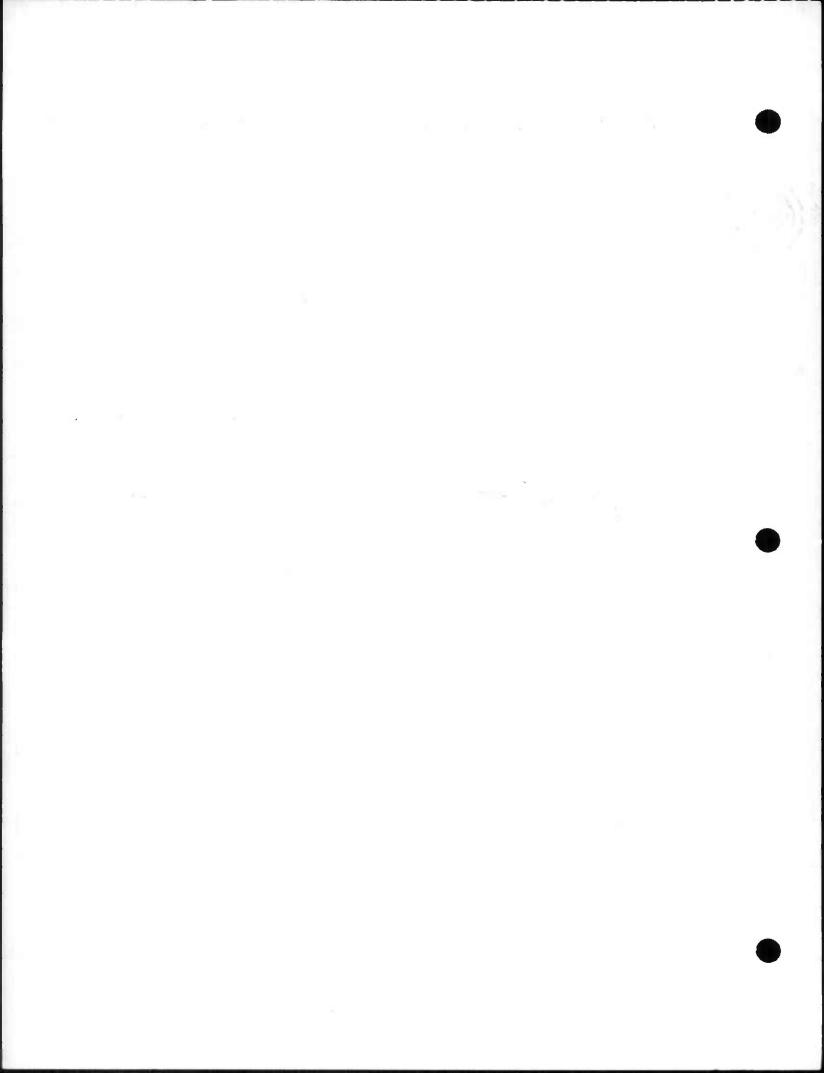
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR CE			F DEATH		EG. NO.	_		
	1. DECEDENT'S NAME (First, Middle, Last) ALFRED VON BOSTEL				2. DATE OF C	EATH	31	19 95	3. TIME OF DEATH
. 1	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. las	at hirthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	JANUA 7. DATE OF B		31		PLACE (State or Foreign
- 1	577-54-1643 1\(\mathbb{R}\) M 2 □ F 83		MONTHS DAY		(Month, Day	(Year)	011	Countr	y)
	9e. FACILITY NAME (If not institution, give street and number)		96. CITY. TOW	N OR LOCATION OF DE	Feb. 2	, l		Gern	
DIRECTOR	Shady Grove Adventist Hospital		Rockvi					tgome	
EC	10e. STATE 10b. COUNTY	10c. CITY,	TOWN OR LO	CATION					10d. INSIDE CITY
5	Maryland Montgomery	Gait	hersbu	ırg					LIMITS?
AL	10e. STREET AND NUMBER			10f. ZIP CODE			10g. CI	TIZEN OF W	HAT COUNTRY?
FUNERAL	14808 Coles Chance Rd.			20878			Ger	many	
5	11. MARITAL STATUS 1 Never Merried 2 Married 12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES 2 Married	RMED	13. WAS (DECENDENT OF HISPAN	HC ORIGIN? (Sp	ecify Yes	or No-	14. RACE	— American Indian, , White, etc.
B⊀	1 Never Married 2 Married 3 Widowed 4 Divorced PORCES? 1 YES 2 MAR OR DATES	•	0 If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: Specify:						
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (G.	CEDENT'S U	ISUAL OCCUP	ATION most of working	18b. KINC	OF BUS	SINESS/IN	OUSTRY	
91	Elementery/Secondery (0-12) College (1-4 or 5 +)	. Do NOT use	retired.)	most or working					
P P		r Dre	sser		Sel:	Em	ploy	ed	
8	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NA					
B	William Adolf Albert H. von B			Frieda				-	Ecklund
٩				et and Number or Rural F					200=0
				Chance Rd.		-			
	EUU. PLACE		er place)	natory				- City or To	
	21. SIGNATURE OF FUNERAL SERVICE INCENSES	POTITE		MALOTY		Атех	cana	ria,	Virginia
	> > 5. 5.		DeVo	l Funeral	Home	Cod	tho	rahum	g, MD 20877
	23. PART I. Enter the diseases, or complications that caused the de	ath. Do no	ot antar tha	mode of dying, such	h es cardiac	or raspi	retory a	rreat.	Approximate
	shock, or heart fallure. List only one cause on each line	١.		, -					intarval Between Onset and Death
	disease or condition	Ho.	460	X-0.					Zdays
	resulting in death) a	OUENCE OF)	:	rescer					- Circlys
Z	disease or condition resulting in death) a. Congestul Due to on as a consecutive and an account of any, leading to immediate	Como	konyo	pally					2+ Suene
CERTIFICATION		QUENCE OF)	: [/						- 1
2	cause. Enter UNDERLYING CAUSE (Disease or injury	Judia	9						2-5 year.
	that initiated avents reaulting in death) LAST	DUENCE OF)	:						
Ы	d								
7	PART ii. Other algolficant conditions contributing to death but not re						AUTOPSY	24b.	WERE AUTOPSY FINDINGS
DICAL	Devention, probably newltin	fact	Truf	ner Well Pryce	while fit	PERFOR	MEO?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME	- Hyperteuring, potemiclis Dep	culent	Dolla	ets Kellets	_ / -				OF DEATH?
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA	TH YES	ON D	M UNCERTAIN	I D I				
8			Check only 6	14)					
<u>i</u>	1 VES 215 NO 10 HORPITAL:		OTHER:	ome 5 🗆 Residence	6 Other (Spe	city)			
PHYSICIAN:	27. MANNER OF DEATH 284. DATE OF INJURY (Morth, Day, War)	26b. TIME INJU		NJURY AT	28d. DESCRIB	E HOW IN	JURY O	CCURED	
B	Pending Accident Investigation			YES 2 NO					
	3 Suicide 6 Could not be determined 28s. PLACE OF INJURY — At hos boilding, etc. (Specify)	me, farm, str	reet, factory, or	ffice	281. LOCATION City or Tow	(Street a	nd Numbe	er or Rural A	oute Number,
Ë.	4 Homicide determined								
<u>a</u>]	29e. CERTIFIER (Check only (Ch	ath occurred	at the fime, d	ate and pleca, and due	to the cause(s)	and men	ner as st	nted,	
COMPLETED	one) 2 MEDICAL EXAMINER: On the basis of exemination and/or I	investigation,	, in my opinion	, death occured at the	time, data and p	olace, and	d due to t	the cause(e)	end manner se stated.
шШ	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUM			29d. DA	TE SIGNED	(Month, Day, Year)
TO B	Sein M. & V			D351	92			Feb.	comy 1, 1995
F	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEN								1
	15001 A het will Rd Com	Vhosh	ing,	40 2087	3				
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	1	/ /						
	FEB 02 1995 Julia Davidson Ra	rdall							

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit is be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.



BALLIMORE, MARYLAND 21215-0020	ours after death. Page 6 may be retained by the hospital or attending physician,	In by the funeral director, page 5 should be detached for use as the burial-transit per	ir removal,	redical examiner must be notified at once.	
Civilian of VII At RECORDS, T.O. BOX 887 80	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,	

											90	U	400) [
	1 - FOR STATE REGISTRAR		STATE OF M		DEPAR					MENTAL HYGII						
	1. DECEDENT'S NAME (First, Mich		1+ 1		P					2. DATE OF DEATH		West	3. TIME O	F DEAT	гн	_
	Olive	Me	lita		ber	The	2			FEBRUAR	11	1995	2.0	0	P	M
	4. SOCIAL SECURITY NUMBER		SEX	8. AGE (in yrs. les	st birthday)	IF UNDE	R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH		8. SIRTN	NPLACE (Sta	ite or Fo	ore/gn	
	198-07-9784	- 1	□ M 2 😾 F	79	YRS.	WORTHS	DAYS	HOURS	MIN.	March 20	1915	Pen	nsylv	ani	La	
~	9e. FACILITY NAME (If not institute	tion, give atreet	end number)			9b. CIT	Y, TOWN O	R LOCATIO	N OF DE	ATN	9c. CO	UNTY OF D	EATH			
6	Shady Grove A	dventi	st Hosp	ital		Roc	kvi1	1e			Mor	itgom	ery			
DIRECTOR		b. COUNTY			10c, CIT	Y. TOWN	OR LOCAT	ION					10d. INSID	DE CITY		
DIR	Maryland Me	ontgom	erv			wood							LIMIT	187		
	10e. STREET AND NUMBER	onegom	CLY		Der	wood		ZIP CODE			10a. Cl	TIZEN OF V	WHAT COUN		NO	_
ER/	7010 Roslyn A	VA					-	0855			1111		State			
FUNERAL	11. MARITAL STATUS		. WAS DECEDEN	T EVER IN U.S. AR	MED	13.			F NISPAN	IC ORIGIN? (Specify			E — America		en	_
	1 Never Married 2 Marr		FORCES? 1	YES 2 N	10		If yes, spe	cify Cuben	Mexican Specify	, Puarto Rican, stc.)		Black Spec/	k, White, atc	2	,	
BY	3 Widowed 4 Divorced							231	ороспу			Speci	Whi	te		
COMPLETED	15. DECEDEN (Specify only high	NT'S EDUCATIO	DN (pleted)	(GI	CEDENT'S	work done	during mos		7	16b. KIND OF	USINESS/IN	IDUSTRY				
Ë	Elementary/Secondary (0-12)	Co	ollege (1-4 or 8+) Ho.	. Do NOT us	se retired.)										
MP	12			Sal	es A	ssoc	iate			Reta	ll Sal	Les				
8	17. FATNER'S NAME (First, Middle,									ME (First, Middle, Meio	,					
BE	Larson Edward									ne Acelia			ain			
2	19e. INFORMANT'S NAME (Type/P									oute Number, City or						
	Christine Nol.	1e							Der	wood, Mai		_				
	20e. METHOD OF DISPOSITION 1 Durial 2 Commettee 3		from State	20b. PLACE A cemetery, cree	AND DATE O)F DISPOS	SITION (Nat	me of			LOCATION -					
	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Set	-	-	Metroj	polit						exand	ria,	Virg	ini	a	
		5 7)				D ADDRES								
	X.(De de			10	E.	Deer	Par	k Dr., Ga	ither	sbur	g, MI	20)87	7
	23. PART i. Enter the disease ahock, or heert	sea, or comp	plications thet	caused the de	ath. Do n	ot anter	r the mod	de of dyin	ng, auch	as cardiac or re	piratory a	rreat,	App	roxima	ete	
	IMMEDIATE CAUSE (Final	·	7	90 OH WEST THIS	•									rval Ba		
	disease or condition resulting in death)	a	Pheru	OR AS A CONSEC									1/	D		
			DUE TO	OR AS A CONSEC	DUENCE OF	7:								C	#	_
2	Sequentially list conditions,	b	Puh	wray	En	phy	5-en	5					10	Dige	oy	
CERTIFICATION	if any, leeding to immediate cause. Enter UNDERLYING		DUE TO (OR AS A ODNSEO	DUENCE OF	5:								0		
길	CAUSE (Disease or injury	c _	DUE TO	00 40 4 000000	2151105 05											
Ē	that initieted events reaulting in death) LAST		DUE TO	OR AS A CONSEC	JUENCE OF):							1			
SE		d														
- 1	PART II. Other aignificent co	onditions co	entributing to	deeth but not re	eaulting i	n the ur	nderlying	ceuse gl	lven in f	Part I. 24s. WAS	AN AUTOPSY	24b.	WERE AUTO			S
3											ORMED?		COMPLETIC	ON OF C		
ME											70.0	1	OF DEATH?	. 1	NO.	
ä	DID TOBACCO USE	CONTRIBI	UTE TO CAI	JSE OF DEAT	TH YE	SZ	NO 🗆	UNCE	RTAIN				. [] .20	- 7		
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO ME EXAMINER?		- 11	28. PLAC	E OF DEAT	H (Check	only one)									_
Sic	1 TES 2 NO		SPITAL:	ER/Outpetient 3	□ DOA	OTHEI		5 🗆 Res	idence 8	Other (Specify)						
3	27. MANNER OF DEATH		28s. DATE OF I	INJURY v. Year)	28b. TIME		28c, INJU	JRY AT		28d. DESCRISE NO	V INJURY OC	CURED				
BY	1 Natural 8 Pendi 2 Accident Priver	ling Itigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	y. 10m/		M		ES 2 [NO							
	3 Suicide 8 Could		28e. PLACE OF	INJURY — At hor	me, farm, s	treet, fact	tory, office			281. LOCATION (Stree City or Town, Sta	of and Number	v or Rural R	loute Numbe	W,		
	4 Nomicide determ	rmined		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						ony or rown, one	,					
COMPLETED	29e. CERTIFIER 1 CERTIFYIN	NO PNYSICIAN	: To the best of	my knowledge, dar	ath occurre	d at the t	time, date	and place,	and due t	to the cause(a) and n	anner ea sta	nted.				-
MO	one) 2 MEDICAL	EXAMINER: OF	n the basis of ex	amination and/or is	nvestigation	n, to my c	opinion, de	eth occure	d at the t	ime, data end place,	end due to t	fre cause(s)) end menn-	or on of	ated.	
ECC	A	CERTIFIED	1					29c. LIÇEN					(Month, Day			
0	Cald XI	Neck	21	MI				7)	65	240		SLUA .		, rear)	ar	_
2	30 NAME AND ADDRESS OF PER	20011 11110 00		~~~				DI	. 0 3	10	1 15	=) Lup	1 24 /	17	75	

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Uen San 32. pegistran's signature Julia d'autism Pardall

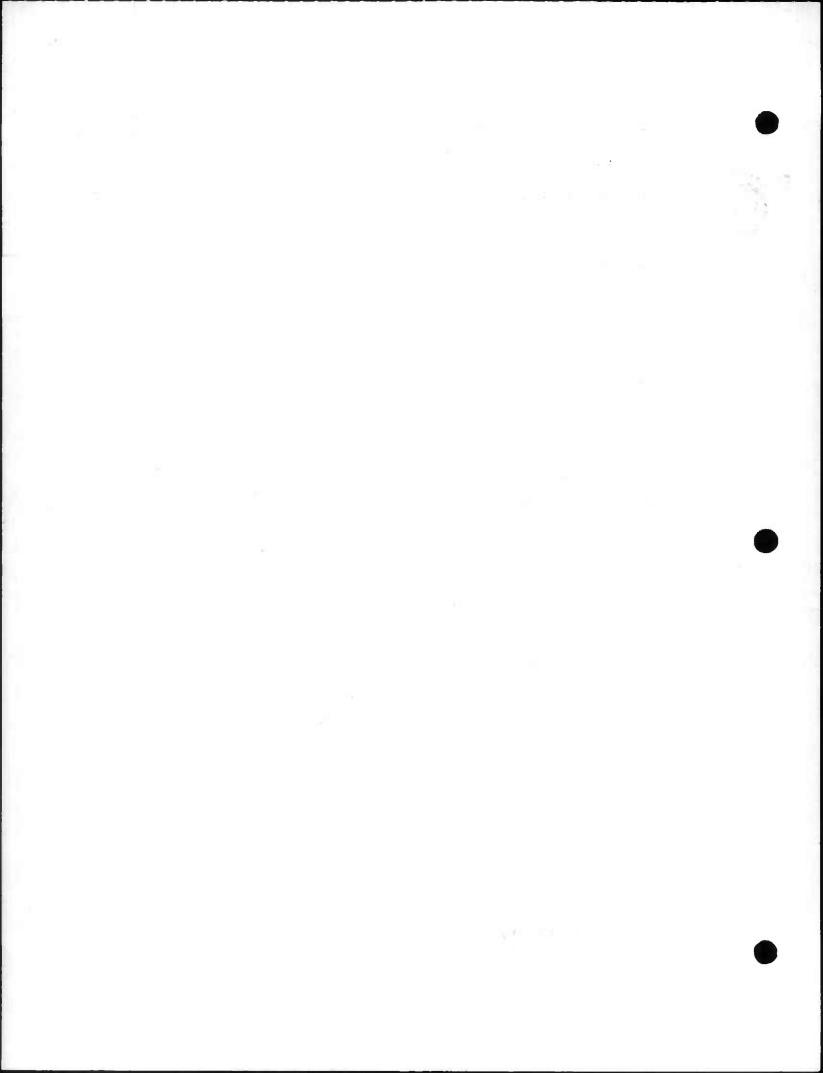
31. DATE FILED GLOOM POY, NOT

1995

¥.

	FOR STATE REGISTRAR	STATE OF MAR	YLAND / DEPAI CERTIF	RTMENT OF I	REALTH AND	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH		YEAR	3. TIME OF DEATH
	ROBERT	THEODORI		ROWN		FEBRUARY			04:15 M
	4. SOCIAL SECURITY NUMBER		GE (In yrs. last birthday) 75 YRS.	919	6. BIRTHP Country	LACE (State or Foreign			
	212-18-1528 9a. FACILITY NAME (If not institution, give		75 YHS.	Ob CITY TOWN	OR LOCATION OF D	Dec. 23, 10071			
H							9c. COUNT		
E	SACRED HEART HO				RLAND, MI	<u> </u>	ALI	EGA	NY.
DIRECTOR		egany		ty, town or loca Vale	TION				10d, INSIDE CITY LIMITS?
	10e. STREET AND NUMBER				I. ZIP CODE		T 100 CITIZI		1 YES 2 NO
FUNERAL	9 Macy Drive				21502		USA	LIT OF IN	HAT COUNTRY?
N N	11. MARITAL STATUS	12. WAS DECEDENT EVE FORCES? 1.X Y	R IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (Specify Ye	s or No— 1		— American Indian,
BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OF	R DATES		2 NO Specif	n, Puerto Rican, atc.) y:			hite
	15. DECEDENT'S EDU		16a, DECEDENT'S	USUAL OCCUPATI	OM .	16b. KIND OF BU	SINESS (INDII		TILLE
E	(Specify only highest grade		(Give kind of life. Do NOT L	work done during mo use retired.)	ost of working			SINI	
COMPLETED	12		Retire	ed Labore	er	Railr	road		
8	17. FATHER'S NAME (First, Middle, Last) Arch Brown					ME (First, Middle, Maiden	Surname)		
H	19a. INFORMANT'S NAME (Type/Print)		J 405 MAII IN	2.40000000 (0		Acute Number, City or Tow			
임	Opal S. Brown					MD 21502	vn, State, Zip C	Code)	
	28e. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Rem		20b. PLACE AND DATE			02/04 Cu	CATION — CI	lfy or Tow	n Stata
	4 Donation 5 Other (Specify)		Sunset Me				mberla	and,	MD
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	,/	Scar	OPERATE FA	deral Home			
	your +	X Cay	RUX	Cumbe	erland, N	1D 21502			
	23. PART / Entar tha diseases, or shock, or haart failure.	complications that could be complications that could be complications that could be complicated as a second complication of the complications that could be complications that could be complications that could be complications that could be complications that could be complications that could be complications that could be complications that could be complications that could be complications that could be complications that could be complications that could be complications that could be complications that could be complications that could be complications that could be complications to the could be complications to the could be complications to the could be complications to the could be complicated by complications that could be complicated by complications to the could be complicated by complications to the could be complicated by complications to the could be complicated by complications to the could be complicated by complications to the could be complicated by complications that could be complicated by complications to the complications to	sad tha daath, Do n aach ilna.	not anter tha mo	da of dying, suc	h as cardiac or resp	iratory arres	st,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition	0-m-	0-1/2-1	1-0	\				Onset and Daath
	resulting in death)	a. DUE TO (OR A	20 VPBCO)\P\~ K	CUBR	100			SMA
z		b.							i /
AT 10	Sequantially list conditions, if any, leading to immediate	DUE TO (OR A	S A CONSEQUENCE C	P):					
E S	cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events	cOUE TO (OR A	S A CONSEQUENCE O)FI:					-
CERTIFICATION	reauiting In death) LAST	4		. ,					İ
	PART II. Other significant condition	a contributing to death	hut not resulting	do the underlyle	n souse short to	Book! Los unos		I am	
MEDICAL	brownes Chellin	S X POSTIC	Rosh	E) SONSE	g cause given in	PERFO	RMED?	1	WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE
ED	Hyperronsal	11/2	WOMA OF	- DIOST		1 TYES	X NO	(OF DEATH?
ž	DID TOBACCO USE CONT					<u> </u>		'	T PYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEA	TH (Check only one)					
YSi	1 TYES 2 MINO	1) Inpatient 2 ER/O			e 5 🗆 Residence	S 🗆 Other (Specify)			
	27. MANNER OF DEATH 1 1 Netural 5 Pending	28e. DATE OF INJUF (Month, Day, Yes		JURY WO	RK?	28d. DEŞCRIBE HOW	INJURY OCCU	REO	
BY	2 Accident Investigation 3 Suicide S Could not be	28a. PLACE OF INJU	JRY — At home, ferm,	atreet, fectory, offic		281. LOCATION (Street	and Number of	r Rumi Ro	ute Number
TEC	4 Homicide determined	building, atc. (S	(pecify)	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, State,)	Y NOVET TIO	oto Hambor,
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the beat of my kn	owledge, death occur	red at the time, date	and place, end due	to the cause(s) and ma	nner as stated	i.	
NO.		ER: On the besis of exemine							and manner as stated.
BE C	296. SIGNATURE AND TITLE OF CENTIFIE	1 10/2	_		29c. LICENSE NUI	MBER	29d. DATE :	SIGNED (Month, Day, Year)
0	KOBUY	Con			D318	75	► FE	BRUA	RY 2/95
	30. NAME AND AGORESS OF PERSON WA								
	WELIK, ROBERT A.	M.D. 902 SI	CTON DRIVI	E,#308, (CUMBERLAI	ND, MD. 2	1502		
	P P D D 2 188	5 AGGISTRAR'S SI	yor Karlell						





FOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trail be filed within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial, cremation, or removal.

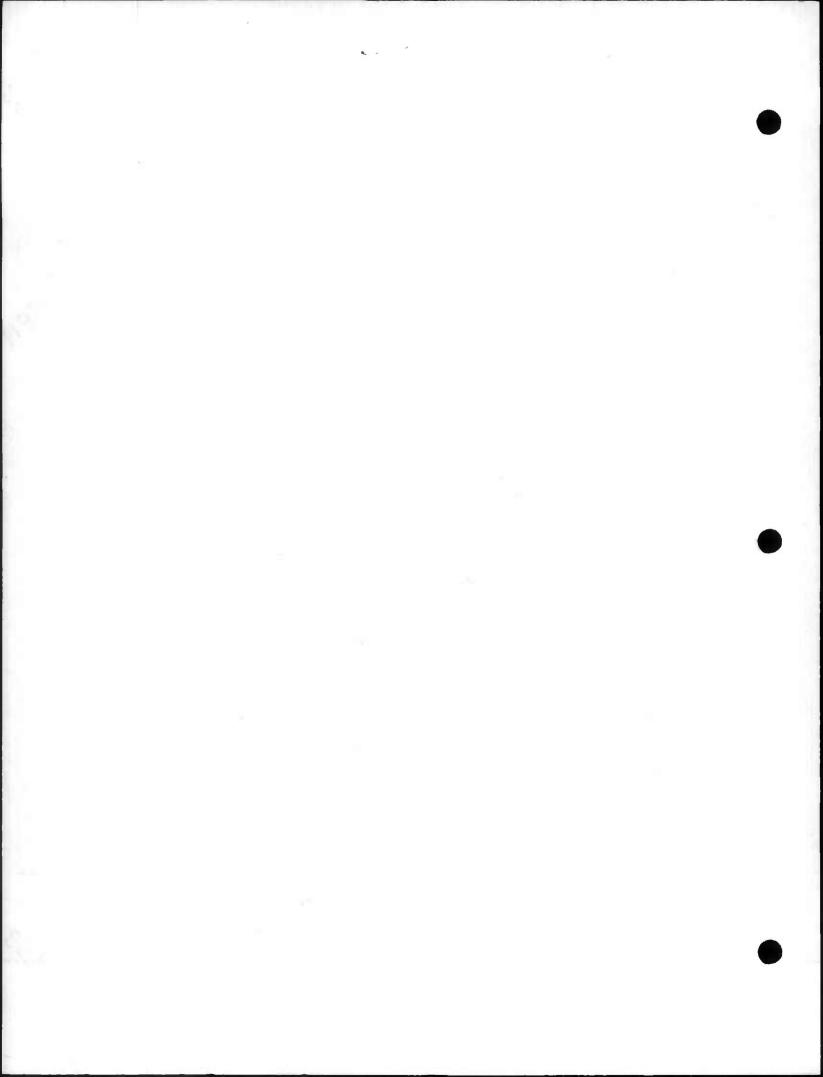
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

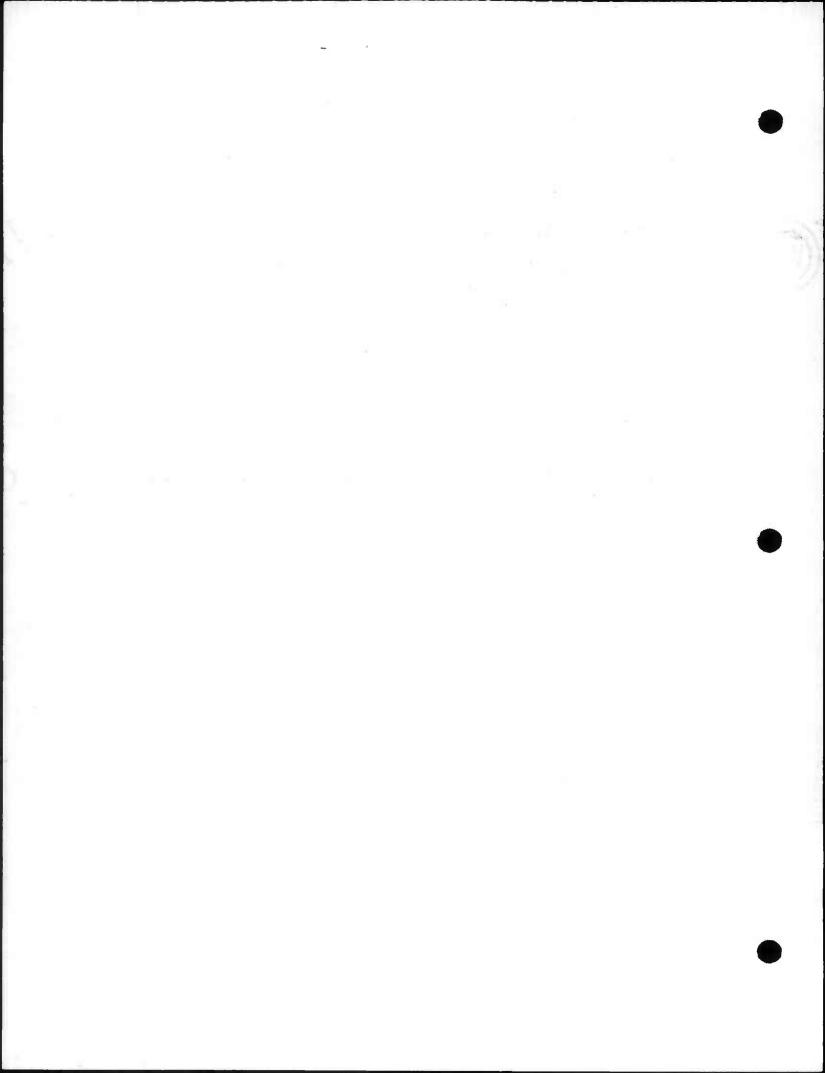
213-22-0124 1 M 2 XF 86 YRS. MONTHS DAYS HOURS MIN. NOVEMBER 10, 190 98. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF	T										
Sarah Rosetta Bond 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 8. AGE (In yrs. last birthday) 9. AGE (In yrs. last birthday) 9. AGE (In yrs. last birthday) 9. CITY, TOWN OR LOCATION OF DEATH 9. COUNTY OF	3. TIME OF DEATH										
4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 X F 8. AGE (In yrs. last birthday) 1 M 2 X F 8. AGE (In yrs. last birthday) 1 M 2 X F 8. AGE (In yrs. last birthday) 1 M 2 X F 8. AGE (In yrs. last birthday) 1 M 2 X F 8. AGE (In yrs. last birthday) 1 M 2 X F 8. AGE (In yrs. last birthday) 1 M 2 X F 8. AGE (In yrs. last birthday) 1 M 2 X F 1 MONTHS 2 MONTHS 2 MONTHS 3 MONTHS 3 MONTHS 3 MONTHS 3 MONTHS 4 MONTHS	95 4:05 pm										
213-22-0124 1 M 2 XF 86 YRS. MONTHS DAYS HOURS MIN. NO VEMBER 10, 190 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF	THPLACE (State or Foreign										
9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF	8 Maryland										
St. Marys Nursing Center Leonardtown St. Marys											
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION											
Maryland St. Marys Leonardtown	10d. INSIDE CITY LIMITS? 1 YES 2 X NO										
10s. STREET AND NUMBER 10s. CITIZEN OF	WHAT COUNTRY?										
518 Peabody St. 20650 U.S	5.A.										
1 Never Married 2 Married FORCES? 1 YES 2 NO It yes, specify Cuben, Mexican, Puerto Rican, etc.)	CE — American Indien, ck, White, atc.										
I Black											
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working the D. NOT use selected) 16b. KIND OF BUSINESS/INDUSTRY											
Elementary/Secondary (0-12) College (1-4 or 5+) 7 Operating Poom P. Tog Hoggital											
7 Operating Room R Tec. Hospital 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surneme)											
Charles Arthur Thompson Sarah Holmes											
Dului: Molinico											
, and the state of											
Mary Travers 18630 Independence Rd., Bryans Road. Md. 2 20t. METHOD OF DISPOSITION 1 Burlel 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place)											
4 Donation 5 Other (Specify) St. Francis Church Cem. 2-4-95 Compton, Marylan											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
M00668 Williams Funeral Home, P.											
23. PART I. Enter the dispesse, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest.											
shock, or feliure. List only one cause on each line. Interval Between Oneet and Death Interval Between Oneet and Death DUE TO (OR AS A CONSEQUENCE OF):											
Sequentieity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 FIND DEATH?											
1 VES 2 PAIG	1 YES 2 NO										
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO Page 125. Was case referred to medical 26. Place of Death (Check only one)											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO P											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO P 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Oulpatient 3 DOA 4 Morring Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 1 Weturel 5 Pending 28. DATE OF INJURY (Morrith, Day, Year) 28. DATE OF INJURY (Morrith, Day, Year) 29. DATE OF INJURY AT WORK? 1 YES 2 NO 1 YES 2 N											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PARTIES AND PA	l Route Number,										
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 1 Impattent 2 ER/Outpettent 3 DOA 4 Murring Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 1 Impattent 5 Pending Investigation 28e. DATE OF INJURY (Morith, Day, Year) 28e. DATE OF INJURY At home, farm, street, factory, office 28e. PLACE OF INJURY — At home, farm, street, factory, office 28f. LOCATION (Street and Number or Rural)	-										
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO P 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Impetient 2 ER/Oulpetient 3 DOA 4 Marring Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 DOA 4 Marring Home 5 Residence 6 Other (Specify) 28c. DATE OF INJURY (Month, Day, Year) 28c. DATE OF INJURY AT WORK? 1 YES 2 NO 26d. DESCRIBE HOW INJURY OCCURED INJURY AT WORK? 2 NO DESCRIBE HOW INJURY OCCURED INJURY AT WORK? 3 Suicide 8 Could not be determined 28c. PLACE OF INJURY At home, farm, street, tectory, office 26f. LOCATION (Street and Number or Rural City or Town, State) 29e. PLACE OF INJURY At home, farm, street, tectory, office 26f. LOCATION (Street and Number or Rural City or Town, State) 29e. PLACE OF INJURY At home, farm, street, tectory, office 26f. LOCATION (Street and Number or Rural City or Town, State)											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO 26. PLACE OF DEATH (Check only one) 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 1 Inpetient 2 ER/Oulpatient 3 DOA 4 Marring Home 5 Residence 6 Other (Specify) 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY (Month, Day, Year) 28. DATE OF INJURY 28. DATE OF INJURY (Month, Day, Year) 28. PLACE OF INJURY AT WORK? 1 YES 2 NO 28. DATE OF INJURY 28. DATE OF INJURY (Month, Day, Year) 28. PLACE OF INJURY AT WORK? 1 YES 2 NO 28. LOCATION (Street and Number or Rural City or Town, State) 29. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To like best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. MEDICAL EXAMINER: On the besis of axamination and/or investigation, in my opinion, death occurred at the lime, date and place, and due to the cause	(s) and manner ea stated.										
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO P 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpatient 3 DOA 4 Minuring Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 2 See. PLACE OF INJURY MINURY NORK? 28e. PLACE OF INJURY NORK? 1 YES 2 NO 2 Sec. INJURY AT WORK? 1 YES 2 NO 2 Sec. INJURY AT WORK? 28e. PLACE OF INJURY AT WORK? 28e. PLACE OF INJURY AT WORK? 28e. PLACE OF INJURY AT WORK? 1 YES 2 NO 2 Sec. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office 2 City or Town, State) 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, desth occurred at the time, data end place, end due to the cause(e) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNE 1 NAME AND ADDRESS OF PERSON WHO COMPLETED ADDRESS OF P	(a) and manner ea stated. (b) (Month, Day, Year)										



BALTIMORE, MARYLAND 21215-0020	24 hours after death. Page 6 may be retained by the hospital or attending princing	O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hyglene prior to burial, cremation, or removal.	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending principles.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the it be filed within 72 hours after death with the State Dept, of Health and Memal Hygliene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CE	RTIFIC	CATE OF	DEATH	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)	0				2. DATE OF DEATH		3	TIME OF DEATH
- 1	GEORGE	PSES	1			FEBUARY	4.1	YEAR 1995	9.15 M
3	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH			ACE (State or Foreign
	579-28-8876 ty № 2 □ F	70		ONTHS DAYS	HOURS MIN.	(Month, Day, Year)	,,, I	Country)	
	99, FACILITY NAME (If not institution, give street and number)	70		OF OUTLY WOULD A		MAY 15, 19			CAROLINA
œ		11 -		400	OR LOCATION OF DE	ATH		NTY OF DEA	~
DIRECTOR	SOUTHERN MANYAND RESIDENCE OF DECEDENT	HOSPIT	7aC	Ch	INTON		Ph	INCE	GEONGES
2	10s. STATE 10b. COUNTY		10c CITY	TOWN OR LOCAT	ION			La	Dd. INSIDE CITY
E	MARYLAND PRINCE GEORGE								LIMITS?
	MARYLAND PRINCE GEORGE		ACCC	KEEK					YES 2 X NO
A.				101	. ZIP CODE		10g. CITI	ZEN OF WN	AT COUNTRY?
9	#17009 OLD MARSHALL HALL				20607		UNIT	ED ST	ATES
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married FORCES? 1	TEVER IN U.S. ARM				IIC ORIGIN? (Specify Yes	or No-	14. RACE -	- American Indien, White, etc.
ВУ	IF YES, GIVE W	AR OR DATES			2 X NO Specify		- 1	Specify:	
	1743 1	946							BLACK
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Giv	e kind of wor	SUAL OCCUPATION of the done during mo	ON st of working	186. KIND OF BUS	SINESS/IND	DUSTRY	
"	Elementary/Secondary (0-12) College (1-4 or 5 +)	Do NOT use						
₹	12TH GRADE	PHO	TOGRA	PHER		INTERNA	ATION	AL GO	VERNMENT
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAI	ME (First, Middle, Malden	Sumame)		
BE	UNKNOWN				EMMA BE	ST			
2	19a, INFORMANT'S NAME (Type/Print)	19b.	MAILING A	DDRESS (Street a	nd Number or Rural F	Noute Number, City or Tow	n, State, Zip	Code)	20607
F	MARY M. BEST	#1	7009	OLD MAR	SHALL HA	LL ROAD, A	ACCOK	EEK,	MARYLAND
	298. METNOD OF DISPOSITION	20b. PLACE A	ND DATE OF	DISPOSITION (Na	me of	DATE 20c. LO	CATION —	City or Town	, Stata
	tX Burlat 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify)	MARYLA	ND VE	TERAN C	EMETERY	2/10/95 CH	HELTE	NHAM.	MARYLAND
- 1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE			22. NAME AN	D ADDRESS OF FAC	CILITY			
	Sydia C. Thurton	popes				AL HOME, I			
_	IA C. THORNTON JOHN								,MD. 20640
	23. PART I. Enter the diseeses, or complications that shock, or heart failure. List only one cause	se on each line.	th. Do no	t enter the mo	de of dying, eucl	n es cerdiec or respl	ratory err	rest,	Approximete Intervel Between
	IMMEDIATE CAUSE (Fine)	4	0.	1					Onset and Death
- 1	IMMEDIATE CAUSE (Fine) disease or condition resulting in death) ASP1	Yalun	Nerve	160					2/4/95
		OR AS A CONSEO							
Z	Sequentially list conditions,	STAJ L	en I	2					
E	If any, leading to immediate	OR AS A CONSEO	UENCE OF):	1 1 1	0/1:				
2	CAUSE (Disease or Injury	OR AS A CONSECU	Jus	Here Sleey 14	Liganly				
E	thet initieted events	OR AS A CONSEC	UENCE OF):						
CERTIFICATION	reaulting in death) LAST	relicio V	nsend	- aicid	녀'				
<u></u>	PART II. Other significent conditions contributing to	death but not re	euitles in	the underlying	s course share to	Bort I Or ung au			
DICAL	TAIL II. Other significant conditions contributing to	death but not re	suiting in	the underlying	ceuse given in	Pert I. 24a. WAS AN PERFOR		AV	ERE AUTOPSY FINDINGS MILABLE PRIOR TO
ă						t YES 2	□ NO		OMPLETION OF CAUSE F DEATH?
ME								t	YES 2 NO
Ë	DID TOBACCO USE CONTRIBUTE TO CAI	USE OF DEAT	'H YES		UNCERTAIN	۱ 🗆 📗			
8	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE		(Check only one)					
is I	t ☐ YES 2 ☑ NO HOSPITAL:	ER/Outpetient 3		OTHER: Nursing Nom-	e 5 ☐ Residence	8 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATN 28s. DATE OF (Month, Da	INJURY	28b. TIME (URY AT RK?	28d. DESCRIBE NOW I	NJURY OCC	CURED	
BY F	1 Part Netural 5 Pending 2 Accident Investigation	y, rour)	INJUR		ES 2 NO				
	3 Suicide 28e, PLACE OF	FINJURY — At home	e, lerm, stre	et, factory, office	,	28f. LOCATION (Street 8	and Number	or Rural Roul	te Number,
COMPLETED	4 Nomicide determined	nc. (Specify)				City or Town, State)			
2	29s. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of a	mu knowledne des	th assumed	et the time date		A STATE OF THE STA			
₽ I	(Check only one) 2 MEDICAL EXAMINER: On the basis of ex								
8			vestigation,	и ну ориноп, о	setti occured at the	time, data and place, en	a dua to th	ie canse(s) at	nd menner as stated,
H	29b. SIGNATURE AND TITLE OF CERTIFIER	2		1	29c. LICENSE NUM	BER	29d. DATE	E SIGNED (M	onth, Day, Year)
2	K. Danack		מו		D 25 6	40	1	4-5	-1995
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUS	E OF DEATH (ITEM	27) (Type, Pi	rint)	0	ué U			20032
	KHUSLOW WAVACH; 1	328	Sou	THERN	HUET	WE U	1195.	How 67	w Dc
	FFB 0 6 1995	SIGNATURE C	nel-11						
	1 EB 0 0 1000	- washin an							



1 - STATE REGISTRAR		SIMIE UF I	MARYLAND C	ERTIF	ICATE	OF I	ALIH DEAT	ANU I TH	MENIAL	HYGIEN REG. NO.	_		
1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF	DEATH			3, TIME OF DEATH
Elena			Basilik	0					Janua	rv 3		YEAR	9:32 A M
4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. la		IF UNDER 1	YEAR	IF UNDER	24 HRS.	7. DATE OF	BIRTH	0, 1.	8. BIRTI	HPLACE (State or Foreign
212-38-4127		1 M 2 X F	66	YRS.	MONTHS	DAYS	HOURS	MIN.	Mar.		028	Count	Greece
9a. FACILITY NAME (If not in					9b. CITY, T	OWN OR	LOCATIO	ON OF DE		NTY OF D			
5205 Brentf		ive			Rockville Montgon								merv
RESIDENCE OF DEC	10b, COUNT	,		L 40. 017	Y, TOWN OR								
Maryland		gomery		_	ckvil	_	PM .						10d. INSIDE CITY LIMITS?
10e. STREET AND NUMBER		8-111-2		I	CKVII.		ZIP CODE			_			1 YES 2 NO
5205 Brentfo	ord Dr	ivo				101. 2	208						WHAT COUNTRY?
11. MARITAL STATUS	ord br	12. WAS DECEDEN	T EVER IN U.S. AI	RMED	13, WA	S DECEN			VIC ORIGIN? (Snacify Yes		USA	E — American Indian,
1 Never Married 2 🔯		FORCES? 1	YES 2 X	NO	11 y	es, spec	Ify Cuba	n, Mexica Specifi	n, Puarto Rica	in, etc.)	0	Blac	k, White, etc.
3 Widowed 4 Divo	rced						22	орчоп				Spec	White
	EDENT'S EDU y highest grade		(0	live kind of v	USUAL OCCI	UPATION ing most	of workin	ng	16b. KI	ND OF BUS	INESS/IN	DUSTRY	
Elementary/Secondary (0)-12)	College (1-4 or 5	+)	Do NOT us						0			
17. FATHER'S NAME (First, M	licicila I not)	0		nome	maker					Own			
Constantine		a							ME (First, Midd		Sumame)		
19a. INFORMANT'S NAME (7			- : 1: k - 10	h MAILING	Annesee /	Street and			ainabl		. 0 7	0.11	
Archilles I	Basili	ko											nd 20852
20a. METHOD OF DISPOSITI		3.			OF DISPOSITION			LVC,	OATE			City or To	
1 St Buriel 2 Cremation 4 C Donation 5 C Other		oval from State	Gate	of H	ther plece) Teaven	Cen	nete	rv	2/2			-	ng, Maryland
21. SIGNATURE OF FUNERA	L SERVICE LIC	reference no	1		22. NA	ME AND	ADDRES	S OF FA	CLUTYHin	es-Ri	nald	li Fu	ineral Home
➤ X\(\(\lambda \)\(\lambda \)\(\lambda \)	TAL	well			11	800	New	Han	noshir	e Ave	enue		erar nome
23. PART I. Enter the di	Iseasea, or o	omplications the	t caused the de	eth Do r	OI enter th	TVEI	Sp	ring	, Mar	yLand	1 20	904	
snock, or no	eart fellure.	List only one ceu	se on each line).	iot emer ti	e mode	or dyn	rig, auci	n aa cardiac	or reap	atory en	rest,	Approximate interval Between
iMMEDIATE CAUSE (Findisease or condition	nei		Parl			0	. 40	9					Onset and Death
resulting in death)		eOUE TO	(OR AS A CONSE	DUENCE OF	OUV	m	Like	MILL	ac				memed
		h.	Card (OR AS A CONSE artu	1001	nonen	tre	, 0.	10.1	Ldina	-11			
Sequentielly list conditi if any, leading to immed	ons,	DUE TO	(OR AS A CONSE	DUENCE OF	F):	-	La	Lew	auxe	asi			
cause. Enter UNDERLYi CAUSE (Disease or Inju		D											
that initiated events resulting in death) LAS		DUE TO	(OR AS A CONSE	DUENCE OF	F):								
rooming in douin, Dio		d											
PART II. Other significa	nt condition	s contributing to	deeth but not i	esulting i	in the unde	riying o	ause g	iven in	Part i. 24	a. WAS AN		24b.	. WERE AUTOPSY FINDINGS
lug k	cothy	roeder	u, se	rere	dear	acce	ulid	× m	There	PERFOR			AVAILABLE PRIOR TO COMPLETION DF CAUSE
edr	dior	nyali			- Ju	26.37	-	1_2.000		E 165 2	-Ano		OF DEATH?
DID TOBACCO U			USE OF DEA	TH YE	S 🗆 NO	рΠ	UNC	ERTAIN	10				1 YES 2 NO
25. WAS CASE REFERRED TO EXAMINER?					TN (Check only								
1 Z YES 2 NO		HOSPITAL:	ER/Outpetlent 3	□ DOA	OTHER:	Home	5 Z Ras	sidence	6 Other (S	pecify)			
27. MANNER OF OEATN		28a, DATE OF (Month, D		28b. TIM		ic. INJUR	Y AT		28d. OESCRI		JURY OC	CUREO	
	Pending Investigation				**	YES		NO					
	Could not be	28a. PLACE O building,	F INJURY — At he atc. (Specify)	me, tarm, s	treet, factory,	, offica			281. LOCATIO	ON (Street a.	nd Number	or Rural F	loute Number,
	determined												
		CIAN: To the best of											
one) 2 MEDI	CAL EXAMINE	R: On the basis of a	camination and/or	investigatio	n, in my opin	ion, deat	h occure	ed at the	time, data and	l place, and	due to th	na cause(s) and manner as stated.
296. SIGNATURE AND TITLE	OF CERTIFIER					2	9c. LICE	NSE NUN	IBER		29d. DAT	E SIGNED	(Month, Day, Year)
Mytel K.	PAU.	manbe	aut,	MD	7	1	70	099	46 m	11	1 (Zi	En 3	1,1904
MAME AND ADDRESS OF	PERSON WH	COMPLETED CAUS	E OF DEATH (ITE	M 27) (Type,	Print)		2	- 11			1	/	11/
Wilfred	KI	Forma	in brau	1	1114	F	COCK	WILL	6 PIK	e A	ock	11/10	Md 20852
31. DATE FILED (Month, Day,)	1995	32. REGISTRA	R'S SIGNATURE	7 11									
I LD OT	כככו	your and	MARIN MONG	all									

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing Froms after death. Page 6 may be retained by the hospital or attending physician.

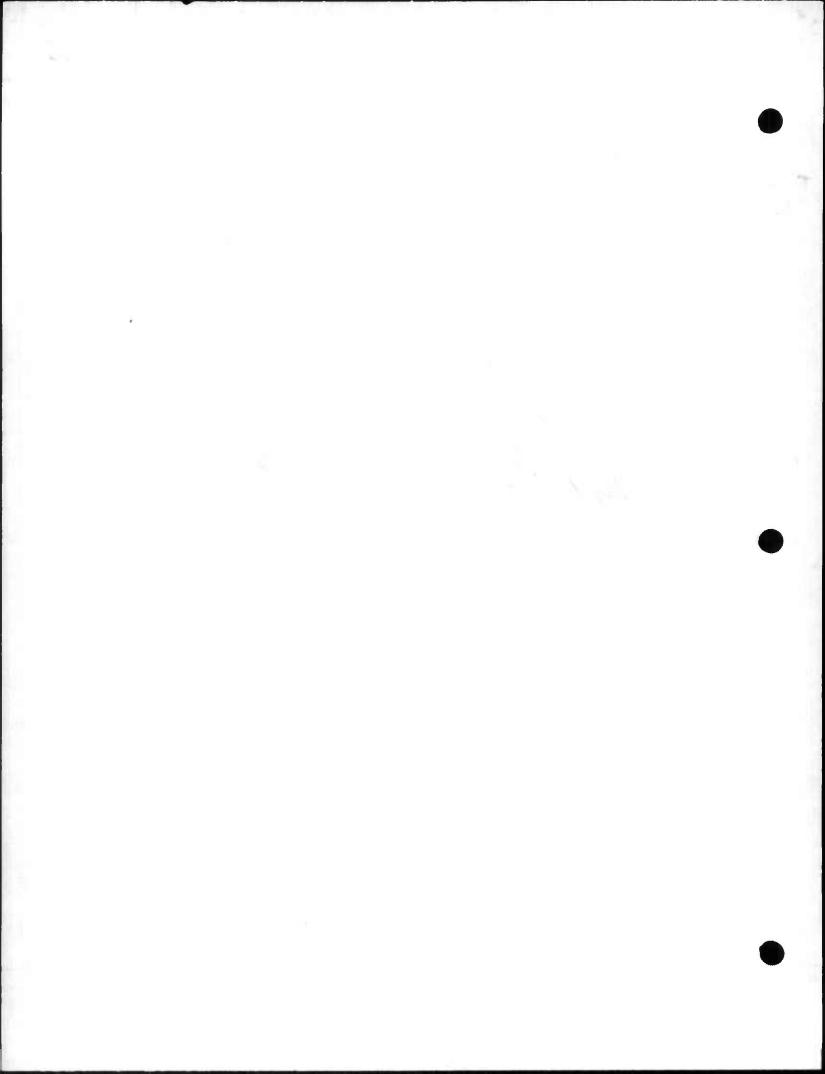
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit personal be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

0 detached the 2 notified at urs after death. Page 6 may be retained by page 5 should pe funeral director, -medicai examiner and completely filled in by the burial, cremation, or removal, executed with and prior to the attending physician Mental Hygiene prior to HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the peen has be 23 this certificate h with the State C irked, or item marked, After t TO THE MOSPITAL OR ATTENDIT TO THE FUNERAL DIRECTOR: AN be filed within 72 hours after de IMPORTANT: If Item 28 is i

must

traumatic event,

or other

shows any

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BE

2

04606 mended #196, 206 2/1 me STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 CAROLYN BULLOCK January 29 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year

5:30 AM BIRTHPLACE (State or Foreign Country) DAYS HOURS 1 M 2 T F 93 YRS. 061 16 9278 June 9,1901 Savannah, GA. 9a. FACILITY NAME (If not institution, give street and number. 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR CARROLL MANOR NURSING HOME HYATTSVILLE PRINCE GEORGE'S RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Washington, D.C. 1X YES 2 NO FUNERAL 10a, STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6316 - 9th St., N.W. 20011 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES If yes, specify Cuben, Maxican, Puarto Ri 1 YES 2 X NO Specify: 1 Never Married 2 Married BY Specify: 3 🔯 Widowed 4 🗌 Divorced **Black** G 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) COMPLET ntary/Secondary (0-12) College (1-4 or 5+) Chef Chase Manhattan Bank 9 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) James B. Simmons Melissa Unavailable BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 Odessa Robinson 9th St., N.W., Washington, D.C. 20011 20a. METHOD OF DISPOSITION
1
Burlal 2 Crayhatlon 3 X Ramoval from Stata 20b. PLACE AND DATE OF DISPOSITION (Name of COALE 20c. LOCATION - City or Town, State National Cem. 17 95 4 Donation 6 Other (Specify) Farmingdale Long Island 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY McGuire Funeral Service Inc. 7400 Georgia Ave. N.W. Wash. D.C 20012 23. PART J Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one ceuse on each line Interval Batwe MMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death ALZHEIMERS DISEASE DUE TO (OR AS A CONSEQUENCE OF) TERMINAL RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF): resulting in death) LAST PART ii. Other algolificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a, WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE BILATERAL HIP ULCERS, GLAUCOMA 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TYES 2 NO 1 Inpetiant 2 ER/Outpetient 3 DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending 1 YES 2 NO ВҰ 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be ED 4 Homicide determined COMPLET 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the films, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE-AND TITUE OF CERTIFIER 29c. LICENSE NUMBER

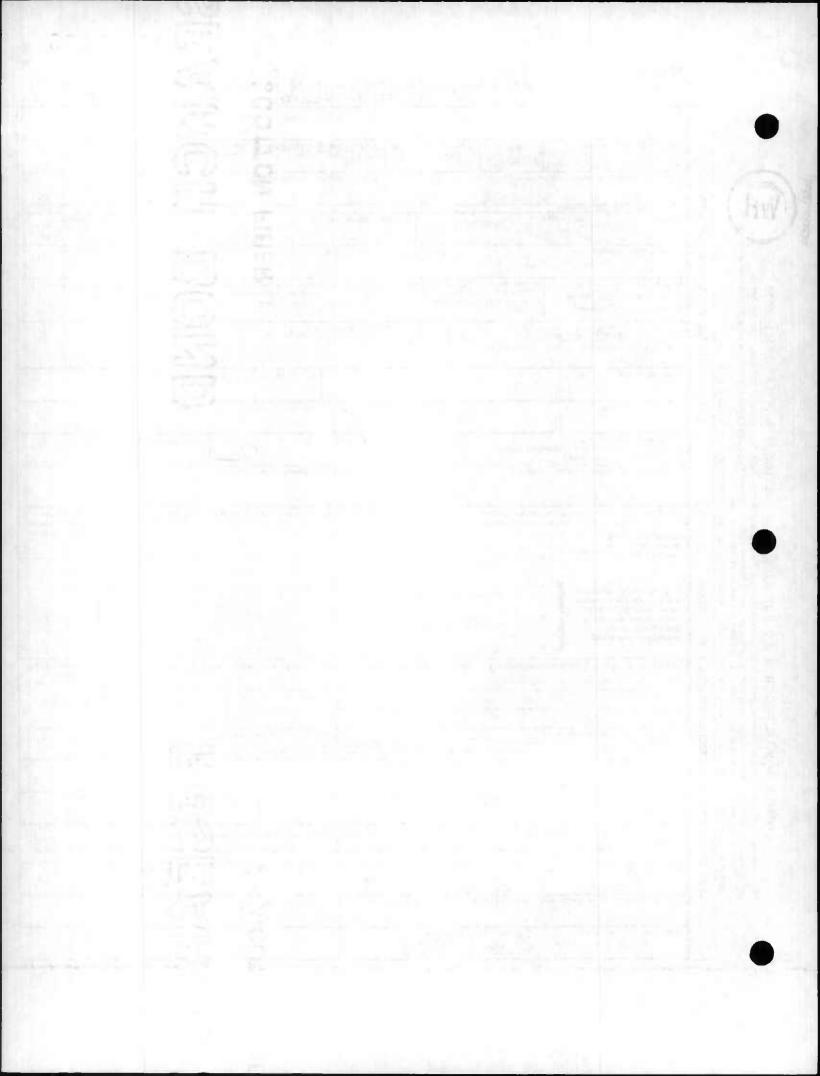
1 Colect D03396 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Robert T. Dibble, PC ,1160 Varnum St., N.E., Washington, D.C. 20017

31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Davelson Reveal FEB 01 1995

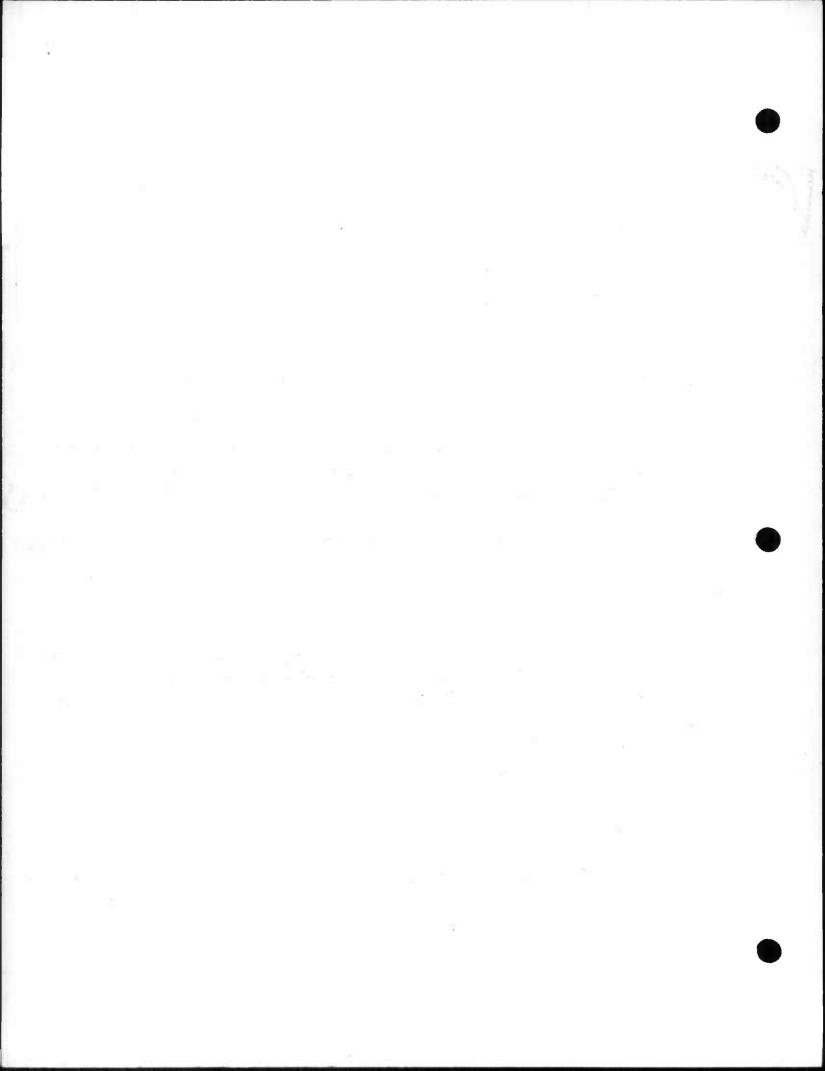
DHMH-16 Rev 1/89

25d. DATE BIGNED (Month, Day, West)



760 BALTIMORE, MARYLAND 21215-0020	ted withlit ze hours after death. Page 6 may be retained by the hospital or attending	completely filled in by the funeral director, page 5 should be detached for use as the al. cremation, or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicis	HE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

			1 - STATE REGISTRAR	STATE OF MARYL			HEALTH AND	MENTAL HYGIEN				
			1. DECEDENT'S NAME (First, Middle, Last) Ellis C Blunt					2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH		
				5. SEX 6. AGE	(In yrs. lest birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF BIRTH	27, 1995	1320 PM HPLACE (State or Foreign		
			061-16-3735	X M 2 □ F	75 YRS.	MONTHS DAY	8 HOURS MIN.	(Month, Day, Year) November	Coun	New York		
1	WH	2	9a. FACILITY NAME (If not institution, give atree Shady Grove Advention of Decement		al	POCKY	N OR LOCATION OF DE		Montgon	DEATH		
\	WII	DIRECTOR	10e. STATE 10b. COUNTY	gomery		v, town on Lo rmantov				10d. INSIDE CITY LIMITS? 1 YES 2 NO		
•	n. Insit perm	FUNERAL	#6 Sunnyview Cour	t			10f. ZIP CODE 20876		10g CITIZEN OF United S	WHAT COUNTRY?		
	MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permotified at once.	ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/	2 NO	If yes,	DECENDENT OF HISPAN specify Cuban, Mexica (ES 2 NO Specify		s or No- 14. RAC	E — American Indian, ck, Whita, etc.		
	21215 al or atten for use as	COMPLETED	15. DECEDENT'S EDUCAL (Specify only highest grade co- Elementary/Secondary (0-12)	TION	16a. DECEDENT'S (Give kind of sille. Do NOT us	vork done durina		16b. KIND OF BU	SINESS/INDUSTRY	WITT CC		
	Ched ched	MPL	12	0	Printer			Newspape	er			
	MARYLAND retained by the hospits 5 should be detached notified at once.	BE CO	17. FATHER'S NAME (First, Middle, Lest) Levi E. Blunt				Elizab	ME (First, Middle, Malden eth Dennis	S			
	E, MAR by be retained page 5 should be notified	10	David A, Blunt		196. MAILING 2319 N	ADDRESS (Street	et Drive,	Crofton, N	Maryland	21114		
	MORE ge 6 may lirector, pa		20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Ramova 4 Donation 5 Other (Specify)	ni from Stata cerr	PLACE AND DATE (Detery, crematory or pr etropoli	tan Cre	ematory	1/30 A1	exandria,	own, Stata , Virginia		
- 6	BALTIMORE, hours after death. Page 6 may be ded in by the funeral director, page or removal.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wuriel H. Barber Funeral Home 20882 21525 Laytonsville Road, Laytonsville, Md.									
	Es after		23. PART I. Enter the diseases, or con shock, or heart fellure. Lis	mplications that caused	the death. Do n	ot enter the	mode of dying, suci	h es cerdiec or resp	ratory errest,	Approximate		
	Within 25 hours after pipterly filled in by the cremation, or removal rem, the medical		IMMEDIATE CAUSE (Final disease or condition resulting in death)	SEPTI	C HI	PJ	OINT			Interval Between Onset and Death		
	687(xecuted and com burial.	NO	Sequentially list conditions, 6.		CONSEQUENCE OF							
	P.O. BOX th certificate be ex ending physician a I Hygiene prior to or other traum	-ICATI	If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury		CONSEQUENCE OF							
	OS, P.O. BOX he death certificate be e the attending physician Mental Hygiene prior to	CERTIFICATION	that initiated events resulting in death) LAST	50E 10 (011 A3 A	CONSCOURNCE OF	<i>j.</i>						
		ايا	PART II. Other significent conditions of							. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO		
	RECORI requires that the open signed by of Health and shows any in	MEDICA	CHRONIC OBST	TRUCTIVE	PULMON	TRIEG	DISTERSE	1 YES 2	N 4	COMPLETION OF CAUSE OF DEATH?		
	RE v requi		DID TOBACCO USE CONTRIE	BUTE TO CAUSE O	F DEATH YE	S IXI NO	INCEPTAIN			1 TYES 2 NO		
	'ITAL N: The law icate has b State Dept item 23	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT	H (Check only or		101				
	CIAN: ertifica the Sta	IYSI		Inpetient 2 - ER/Outp			ome 5 🗆 Rasidence					
	ISION OF ITENDING PHYSI TOR: After this of after death with 28 is marked,	ВУ РЬ	1 Netural 5 Pending 2 Accident Investigation	28a. OATE OF INJURY (Month, Day, Year)	28b. TIMI	M 1	INJURY AT WORK?	28d. DEŞCRIBE HOW I				
	DIVISION OF VITAL RECOR OR ATTENDING PHYSICIAN: The law requires that DIRECTOR: After this certificate has been signed by hours after death with the State Dept. of Heatth and Item 28 is marked, or item 23 shows any	ETED	3 Suicide 8 Could not be determined	28a. PLACE OF INJURY building, atc. (Spec	iffy)			281. LOCATION (Street City or Town, State)). 	Route Number,		
	Z Z Z E	COMPLETE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA 2 MEDICAL EXAMINER: (s) and manner as stated.		
	TO THE HOSPIT TO THE FUNER DE filed within	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER With welf Aug 30. NAME AND ADDRESS OF PERSON WHO CO	dears,	M.D.		DZ97	730		(Month, Day, Year) 189 27, 1945		
2	0+1		MICHAEL ANCHOR	25 MS 162	20 FR		CKRDS	T. 210, 6	FAI THE	SBURG M		
)			JAN 30 1995	Julia Dandes				*		DMMI 12 Sau 1/80		



1 - STATE REGISTRAR		STATE OF M				HEALTH AND	MENTA	L HYGIEN	E				
1. DECEDENT'S NAME (First				2. DATE OF DEATH 3. TIME OF DEATH									
CARL		BASCH			JANUARY 26, 1995				1:17 P. w				
4. SOCIAL SECURITY NUME		6. AGE (In yrs. la		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BIRTH				PLACE (State or Foreign			
151-32-3142 9a. FACILITY NAME (If not in	1 M 2 F	84	5. John 3, 1910										
SUBURBAN HO		control in the c	1		BETHESDA								
RESIDENCE OF DECEDENT										GOPIEKI			
MARYLAND		CKVILL					10d. INSIDE CITY LIMITS? 1XXYES 2 NO						
10e. STREET AND NUMBER											10g. CITIZEN OF WHAT COUNTRY?		
1801 E. JEFFERSON STREET, #610 20852									UNITED STATES				
1 Never Married 2 1 Married FORCES? 1 YES 2 K NO If						CENDENT OF HISPA	n, Puerto I	N? (Specify Yes Rican, atc.)	or No-	14. RACE Black	— American Indian, , White, atc.		
3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES						S 2 X NO Specif	fy:			Specif	WHITE		
15. DEC (Specify on)	EDENT'S EDU y highest grade	CATION completed)	(0	live kind of wo	SUAL OCCUPAT	TON nost of working	16b	. KIND OF BUS	INESS/IND	USTRY			
Elementary/Secondary (C	1-12)	College (1-4 or 5+) 5+	Me	DENTI				DEN	TIST	RY			
17. FATHER'S NAME (First, M						18. MOTHER'S NA	ME (First, I	Middle, Malden	Surname)				
LOUIS BASCH BERTHA WEISS													
19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN BASCH (WIFE) 1801 E. JEFFERSON ST., #610 ROCKVILLE, MD 20852													
20a. METHOD OF DISPOSIT 1 XBuriel 2 Cremetic 4 Donation 5 Other	n 3 🗆 Rem	oval from State	20b. PLACE	AND DATE OF	DISPOSITION (DAT	E 20c. LOC	CATION —	City or Tox	wn, Stata		
21. SIGNATURE OF BUNERA		CINSEE	JUDEA	IN MEM			1/2	9 OLN	EY, 1	MARYI	LAND		
· Ma	DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.												
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
23. PART i. Enter the d	lseeses, or o	complications that	caused the de	ath. Do no	11170 t enter the m	ROCKVILLE ode of dying, suc	PIK	E, ROC	KVILI	LE, N	Approximate		
shock, or h iMMEDIATE CAUSE (Fir	eart fellure.	complications that List only one caus	caused the de e on each line	eath. Do no	11170 t enter the m	ROCKVILLE	h as card	E, ROC	KVILI	LE, N			
shock, or h	eart fellure.	List only one caus	e on each line	ð.	t enter the m	ROCKVILLE ode of dylng, suc S SYNDROM	h as card	E, ROC	KVILI	LE, N	Approximate interval Between		
shock, or h iMMEDIATE CAUSE (Fir disease or condition	eart fellure.	e. ADULT R	ESPIRAT	ORY D	ISTRES	ode of dying, suc	h as card	E, ROC	KVILI	LE, N	Approximata interval Between Onset and Deeth		
shock, or h iMMEDIATE CAUSE (Fir disease or condition resulting in desth) Sequentielly list conditi	eart feilure.	e. ADULT R DUE TO (6	e on each line ESPIRAT DR AS A CONSE	CORY D	ISTRES	ode of dying, suc	h as card	E, ROC	KVILI	LE, N	Approximata interval Between Onset and Deeth		
shock, or h iMMEDIATE CAUSE (Fir disease or condition resulting in desth) Sequentially list condit if any, leading to imme- ceuse. Enter UNDERLY!	ions, diate	e. ADULT R DUE TO (c) DUE TO (c) DUE TO (c)	ESPIRAT OR AS A CONSE IA OR AS A CONSE	CORY D OUENCE OF):	ISTRES	ode of dying, suc	h as card	E, ROC	KVILI	LE, N	Approximate interval Between Onset and Deeth 4 WEEKS 5 WEEKS		
shock, or h iMMEDIATE CAUSE (Fit disease or condition resulting in death) Sequentially list condit if any, leading to imme- ceuse. Enter UNDERLY! CAUSE (Disease or inju that initiated events	ions, diate	e. ADULT R DUE TO (C DUE TO (C CONGEST	ESPIRAT OR AS A CONSE IA OR AS A CONSE	CORY DOUENCE OF): ART FA	ISTRES	ode of dying, suc	h as card	E, ROC	KVILI	LE, N	Approximate interval Between Onset and Deeth		
shock, or h iMMEDIATE CAUSE (Fir disease or condition resulting in desth) Sequentially list condit if any, leeding to imme- ceuse. Enter UNDERLY/ CAUSE (Disease or inju	ions, diate	e. ADULT R DUE TO (C DUE TO (C CONGEST	ESPIRATOR AS A CONSE	CORY DOUENCE OF): ART FA	ISTRES	ode of dying, suc	h as card	E, ROC	KVILI	LE, N	Approximate interval Between Onset and Deeth 4 WEEKS 5 WEEKS		
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transpace filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68769

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

JAN 31 19

1995

32. REGISTRAR'S SIGNATURE

White

DIRECTOR

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CAUSE (Disesse or Injury

that initiated events resulting in death) LAST

burial-transit

Page 6 may be retained by the hospital or attending physician.

hours after death.

executed

death certificate be

and completely filled in by the 1 burtal, cremation, or removal.

funeral director, page 5 should be detached for use as the

BALTIMORE, MARYLAND 21215-0020

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

578-46-5991

IF UNDER 1 YEAR

DAYS

HEG. NO.				
2. DATE OF DEATH MONTH DAY	YEAR	3. TIME OF D	EATH	
February 1, 19	95	5:	20	P
7. DATE OF BIRTH (Month, Day, Year)	Countr	PLACE (State o		gn
March 21,1905	Wash	ington	, [OC

9c. COUNTY OF DEATN

9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATN Potomac Valley Nursing Home

YRS.

6. AGE (In yrs. lest birthday)

89

Gladys Saltzman Burgess

5. SEX

15. DECEDENT'S EDUCATION

1 M 2 1

Rockville Montgomery

16b. KIND OF BUSINESS/INDUSTRY

IF UNDER 24 HRS

HOURS

RESIDENCE OF DECEDENT 10a STATE 10h COHNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Rockville 1 TES 2 NO

10a STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 4004 Beverly Road 20853 United States 11 MARITAL STATUS

12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Maxican, Puerto Ricen, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 2 NO 3 X Widowed 4 Divorced

16a. DECEOENT'S USUAL OCCUPATION (Specify only highe (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Homemaker Own Home

17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) Ernest Clifford Saltzman Anna Bell Reno

19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert S. Burgess 179 E. Highland Drive, McMurray, Pennsylvania 15317

20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 2/3/95 OATE 20c. LOCATION — City or Town, State Burlal 2 X Cremation 3 - Removal from State 4 Donation 6 Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland

22 NAME AND ACCRESS OF FACILITY
Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc.
7557 Wisconsin Ave., Bethesda, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00198 alu Jan 20814-3501

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, **Approximate** shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition_ Multi-infarct Dementia reaulting in dasth) DUE TO (OR AS A CONSEQUENCE OF)

Cerebral Atherosclerosis Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING

DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 X NO OF DEATH? 1 TYES 2 X NO

February 2,1995

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL

OTHER:
4 & Nursing Nome 6 Realdence 6 Other (Specify) 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 26b.

28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT TIME OF 28d, DESCRIBE NOW INJURY OCCURED 1X Natural 5 Pending М 1 YES 2 NO vestigation 2 Accident

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide determined

29a, CERTIFIER 1X CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

2 __ MEDICAL EXAMINER: On the beats of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

D18084

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

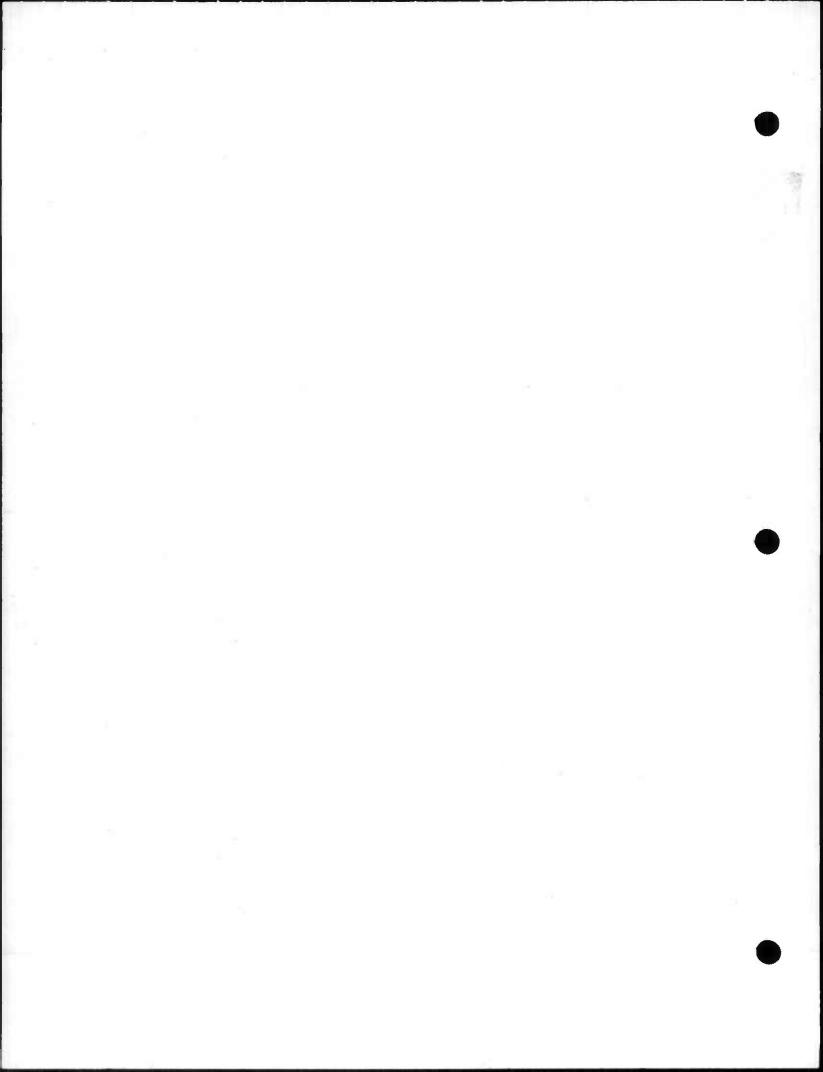
Dineshbhai Patel, M.D., 6121 Montrose Road, Rockville, Maryland

32. REGISTRAR'S SIGNATURE 31. DATE FILEO (Month, Day, Year) 03 1995 B

6220

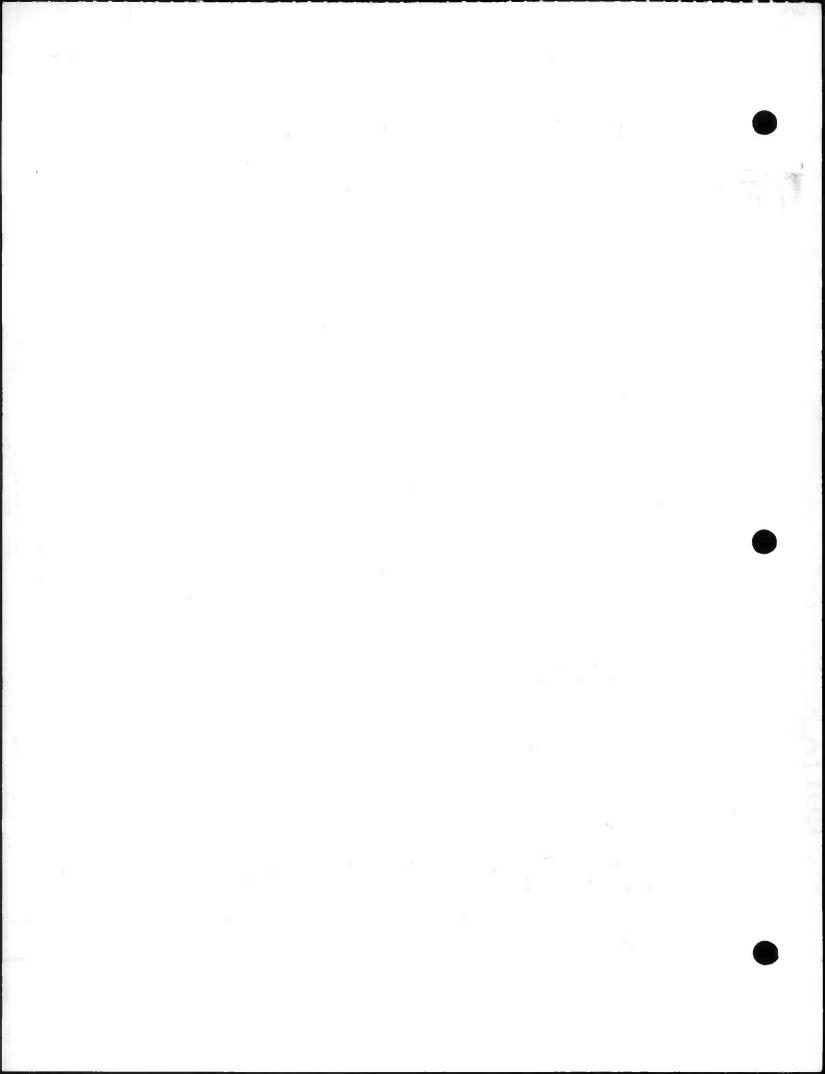
DIVISION OF VITAL RECORDS, P.O. BOX 68760 OR ATTENDING PHYSICIAN: The law DIRECTOR: / THE HOSPITAL (THE FUNERAL D filed within 72 h TO THE HOSPIT TO THE FUNERA De filed within 7

20



100 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, La 2. DATE OF DEATN SteJanuary 1995 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH
(Month, Day, Year)
July 30,1902 577-07-2209 1 X M 2 - F 92 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN Laurel Columbia FUNERAL DIRECTOR Howard County Hospital Howard RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince Georges Laurel 1 - YES 2 1 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6904 Bradford Court 20707 UA USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yes, specify Cuban, Mexicen, Puarto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY White 3 🕅 Widowed 4 🗌 Divorced CI. 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade ᇤ College (1-4 or 5+) Elemantery/Secondary (0-12) COMPL Underwriter Insurance 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Meiden Surn Marcellus Bowie Catherine Aiken BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1416 Thorton Road Rockville, Maryland 20851 Henry Bowie, Jr. 20a. METNOD OF DISPOSITION
1 N Burlal 2 Cremation 3 Ramoval from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE Gate of Heaven Cemetery 1/28/95 Silver Spring, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr., MD 20901 moth 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate intervai Between Onset and Deeth IMMEDIATE CAUSE (Finei disease or condition_ NEUMBRIA resulting in deeth) CERTIFICATION Sequentielly list conditione, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL COMPLETION OF CAUSE 1 YES 2 70 OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER: 1 YES 2 Inpatient 2 - ER/Outpatient 3 - DOA ig Homa 5 - Residence 6 - Other (Specify) 28e. DATE OF INJURY 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO ВУ 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner ea stated. (Check only one) occured at the time, data and place, and due to the cause(e) end manner as stated. 29b. SIGNATUR BE 29d. DATE SIGN 2 ELLI COTT

DHMH-18 Rev 1/89



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	fter	ir death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	to monday or flow 32 shows and inferent or other message account the months and married to matthew as a con-
	Y.	o de	

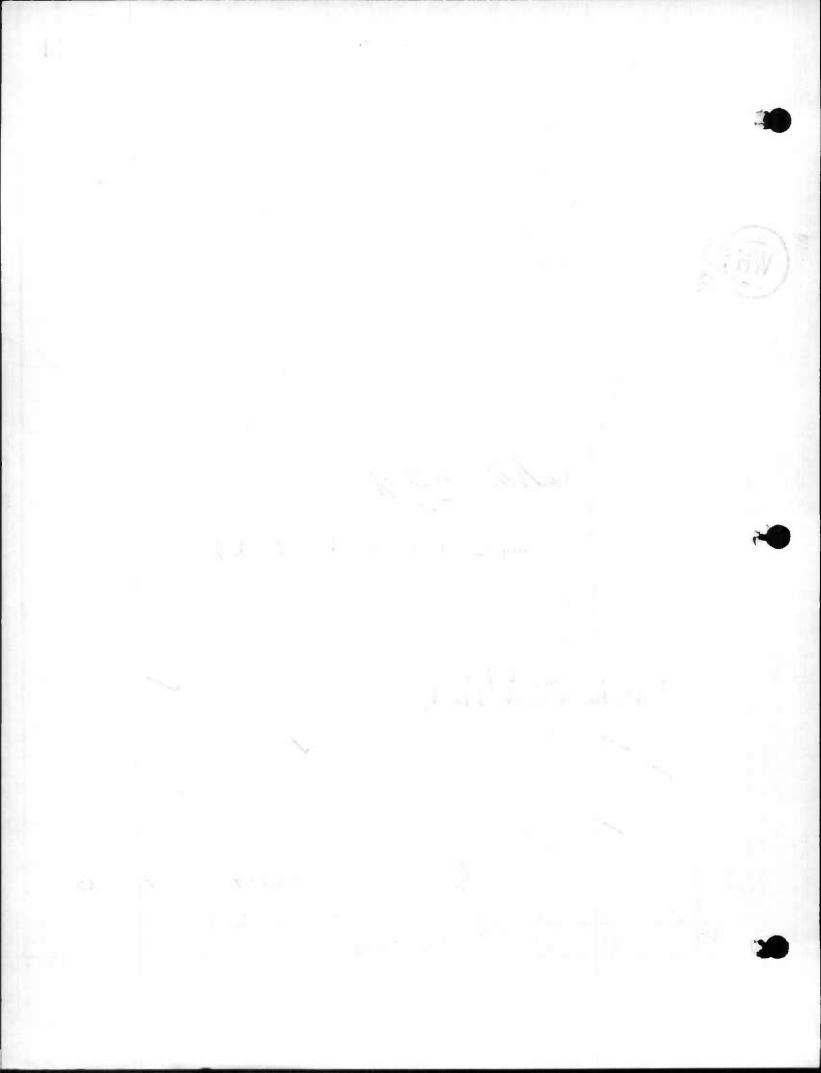
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	Piges 1, 2, 3 should	,
oftal or attending market	d for use as the lumin transmit them 1, 2,	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a mours after death. Page 6 may be retained by the hospital or attend	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the with the State Deer, or Health and Mental Hotelee prior to burial, cemariton, or removal	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
executed within 2 hours after death	in and completely filled in by the fune to burial, cremation, or removal	umatic event, the medical exam
w requires that the death certificate be	certificate has been signed by the attending physician and completely filled in by the it the State Debt, of Health, and Mental Hydiene prior to burial, cremation, or remnyal	shows any injury, or other tra-
OR ATTENDING PHYSICIAN: The law	TO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dent	MPORTANT: If item 28 is marked, or item 23
TO THE HOSPITAL	TO THE FUNERAL be filed within 72 h	IMPORTANT: IF

BALTIMORE, MARYLAND 21215-0020

ST	ATE (0F	MARYLAND	1	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYG	IENE
			C	E	ERTIFICATE	O	F DEAT	Ή		REG	NO

	1 - FOR STATE OF MARY		MENT OF HEALTH AND	MENTAL HYGIENE REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)		ALL OF BEATH	2. DATE OF DEATH	3. TIME OF DEATH
	William Edwin Cain Sr.			January 4,	1995 0400 M
			UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
	221-09-8050 1 X M 2 G F 8	B1 YAS.	DAYS HOURS MIN.	May 3, 1913	
FUNERAL OFFECTOR	5666 Walnut Street (At Hon		Rock Hall		Kent
12	10e. STATE 10b. COUNTY	10c. CITY, T	OWN OR LOCATION		10d. INSIDE CITY
P P	Maryland Kent 10e. STREET AND NUMBER		Rock Hall	1 404	1 X YES 2 NO
là.	5666 Walnut Street		21661		United States
是	11. MARITAL STATUS 12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Yes or N	Io- 14. RACE - American Indian.
By B	1 Never Married 2 Married FORCES? 1 YE IF YES, GIVE WAR OR		If yes, specify Cuben, Maxico		Black, White, atc. Specify:
					White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S US (Give kind of work life. Do NOT use of	done during most of working	166. KIND OF BUSINES	SS/INDUSTRY
12	Elementary/Secondary (0-12) College (1-4 or 5+)	Walter France		77: 1:	T 1
NO.	17. FATHER'S NAME (First, Middle, Last)	Waterman		F1Shing AME (First, Middle, Maiden Sumi	Industry
EC	Eugene R. Cain			Revbold	arrie)
O BI	19s. INFORMANT'S NAME (Type/Print)	19b. MAILING AE	DRESS (Street and Number or Rural		ate, Zip Code)
١٢	Mrs. Eva Cain		<u>lnut Street, R</u>		
	20a, METHOD OF DISPOSITION 1 M Buriel 2 Cremation 3 Removal from State	b. PLACE AND DATE OF	DISPOSITION (Name of	DATE 20c LOCATIO	ON — City or Town, State
	4 Donation 5 Other (Specify)	esley Ceneter	y - January 6, 19	95 Rock H	all, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENSE	7.1.5	Fellows - Wel	ls Fineral Ho	ome
	William L. King Jr.	-//	Maryland Route 2		
	23. PART I. Enter the diseases, or complications that caus shock, or heart failure. List only one cause on	ed the deeth. Do not	enter the mode of dying, suc	h as cardiac or respirato	
	IMMEDIATE CAUSE (Finel	. ^	0 1		Interval Between Onset and Death
	resulting in death) a. my oca	A CONSEQUENCE OF):	farction la	cute)	
_	DUE TO (OH AS	A CONSEQUENCE OF):			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	A CONSEQUENCE OF):			
3	Cause. Enter UNDERLYING CAUSE (Disease or Injury				
분	that initiated events DUE TO (OR AS resulting in death) LAST	A CONSEQUENCE OF):			
뜅	d				
AL.	PART II. Other significant conditions contributing to death	but not resulting in t	he underlying ceuse given in	Part I. 24s. WAS AN AUTO PERFORMED	
EDIC	congestive heart tails	ice		1 YES 2	COMPLETION OF CAUSE
WE WE	L. bundle branch bl	ock		_	1 TYES 2 NO
ä					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	10	28. PLACE OF DEATH (Ch	eck only one)	
₹	1 VES 2 NO 1 Inpatient 2 ER/Ou 27. MANNER OF DEATH 28e. DATE OF INJURY	tpatient 3 DOA 4	☐ Nursing Home 5 Residence		
	1 Natural 5 Pending (Month, Day, Year)		F 28c, INJURY AT WORK? M 1 YES 2 NO	28d. DEŞCRIBE HOW INJUR	N OCCURED
ВУ	2 Accident Investigation 3 Suicide 8 Could not be 28e. PLACE OF INJUR	IY — At home, farm, atre-		261, LOCATION (Street and N	lumber or Rural Route Number.
TED	4 Homicide determined building, atc. (Sp.	ecify)		City or Town, State)	arrived of the Proposition of th
JE I	29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my kno	wiedge, death occurred a	t the time date and place and due	to the course(s) and manner of	
COMPLET	one) 2 MEDICAL EXAMINER: On the basis of examinati				
Ü	29b. SIGNATURE AND TITLE OF CERTIFIER		29c, LICENSE NUI		I. DATE SIGNED (Month, Day, Year)
8	h	>	0333		1-5-25
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF O	EATH (ITEM 27) (Type, Pri			
	Michael Bienenteld	Medical	Bldg. Che	stertown	md.
10	31. DATE FILED (Month, Day, Year) JAN 0 6 '95 JAN 0 6 '95		0		
	JAN 0 6 '95 Gulia	Davidson-Rand	all		



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

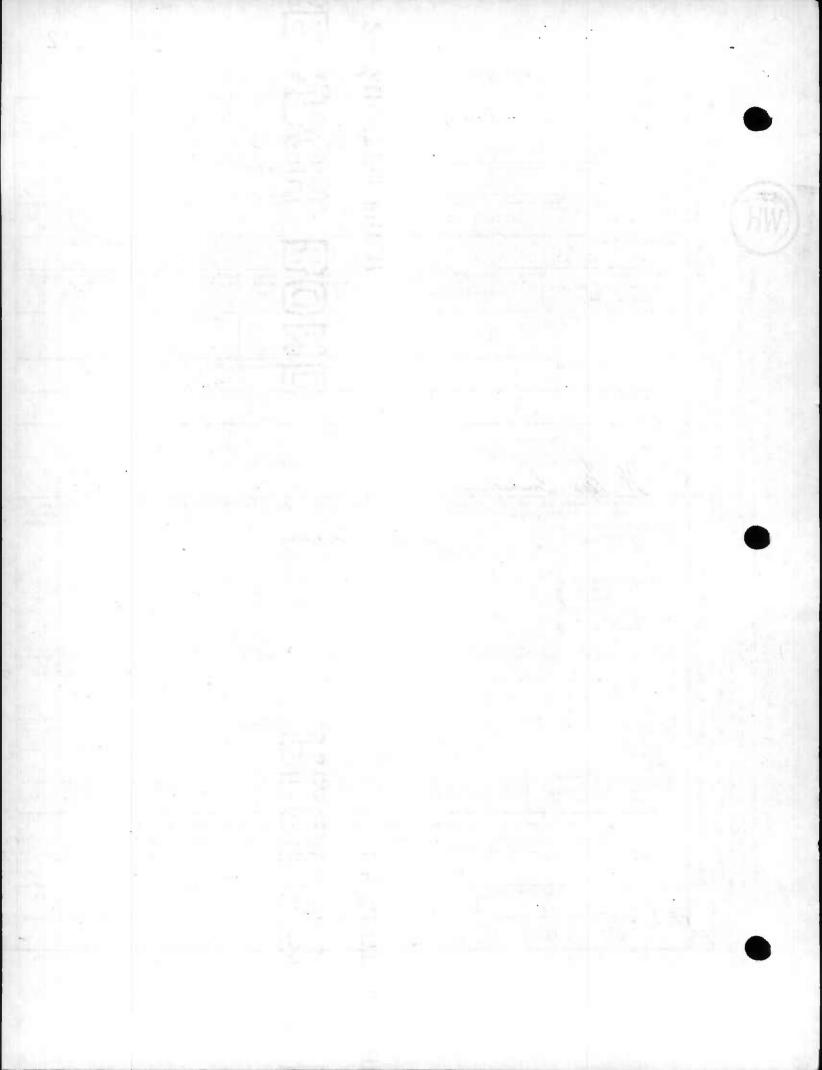
BEG NO.

1. DECEDENT'S NAME (First, Middle, Lest) Margaretta Timmons Carmel 4. SOCIAL SECURITY NUMBER 220-03-1245 1 M 2 K F 82 YRS. 90. FACILITY NAME (If not institution, give street and number) 90.6 Philadalphia Ave	(II.4. 4) (D. 14.)	95 3. TIME OF DEATH 95 11:49 A									
4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 F 82 YRS. 5. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 9. FACILITY NAME (If not institution, give street and number) 9. FACILITY NAME (If not institution, give street and number)	1 23 s. 7. DATE OF BIFTIN	95 11:49 A									
220-03-1245 1 M 2 F 82 YRS. MONTHS DAYS HOURS MIN. 96. EACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF	s. 7. DATE OF BIRTH										
9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF	3/16/12										
		Country) DE									
One Philadelphia Ave	DEATH 9	c. COUNTY OF DEATH									
906 Philadelphia Ave. Ocean City Worcest											
MD 106. COUNTY Worcester 10c. CITY, TOWN OR LOCATION OCEAN City		10d. INSIDE CITY LIMITS? 1/2/YES 2 \[\] NO									
100. STREET AND NUMBER 906 Philadelphia Ave. 21842		09. CITIZEN OF WHAT COUNTRY?									
11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO If yes, specify Cuban, Mexital YES, GIVE WAR OR DATES 13. WAS DECENOENT OF HISI If yes, specify Cuban, Mexital YES, GIVE WAR OR DATES		No- 14. RACE American Indian, Black, White, etc. Specify: White									
15. OECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working	16b. KIND OF BUSINI	ESS/INDUSTRY									
Elementary/Secondary (0-12) College (1-4 or 5 +) life. Do NOT use retired.) Hotel owner/operate	or Hotel										
	NAME (First, Middle, Maiden Sur										
Charles H. Timmons	Jarman										
196. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rul											
Elizabeth Clendaniel 206 7th St. Oce											
20e. METHOD OF DISPOSITION 1 (S/Burlel 2 Cremation 3 Removal from State 4 Donellon 5 Other (Specify) EVEROPE CEMETER)		rion — City or Town, State									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF		08 Williams St.									
Burbage Fu		Berlin, MD 21811									
IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING											
CAUSE (Disease or Injury that Initiated events resulting in death) LAST											
PART if. Other significant conditions contributing to death but not resulting in the underlying cause given	In Part I. 24s. WAS AN AU	TOPSY 24b. WERE AUTOPSY FINDIN									
	PERFORME 1 YES 2	D? AVAILABLE PRIOR TO									
	_ 14										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2	0.00										
27. MANNER OF DEATN 288. DATE OF INJURY 280. TIME OF 280. INJURY AT	26d. DESCRIBE NOW INJU	IRY OCCURED									
1. Natural 5 Pending (Month, Dey, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO											
3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, ferm, etreet, fectory, office building, etc. (Specify)	261. LOCATION (Street and City or Town, State)	Number or Rural Route Number,									
29e. CERTIFIER (Check only CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end of											
(Check only one) 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at											
		9d, DATE SIGNED (Month. Day. Year)									
one) 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE I		9d. DATE SIGNED (Month, Day, Year)									
one) 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE I	NUMBER 2										

ours after death. Page 6 may be retained by the hospital or attending physician. illed in by the funeral director, page 5 should be detached for use as the burial-trans BALTIMORE, MARYLAND 21215-0020 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the host TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burfal, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

DHMH-16 Ray 1/89



BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

DIRECTOR

FUNERAL

BY

COMPLETED

BE

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CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

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27.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

permit. page 5 should be detached for use as the burial-transit Page 6 may be retained by the hospital or attending physician. notified at Pe must the funeral director, medical examiner hours after death. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remo the or other traumatic event, THE HOSPITAL OR ATTENDING PHYSICIAN: The law I THE FUNKRAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. 23 6 28 is marked, TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: It item 2

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH FEBRUARY BABY BOY В CRUMP 1995 7 11:15 A M DATE OF b. (Month, Day, Year 4, 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS 1 🔀 M 2 🗌 F YRS FEB. MD 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH THE JOHNS HOPKINS HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE, 1 X YES 2 NO MD. 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 3524 E. BALTIMORE STREET 21224 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yee, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Merried 2 Merried 2 NO 3 Widowed 4 Divorced BLACK 18e. DECEOENT'S USUAL OCCUPATION 15. DECEDENT'S EOUCATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) RUBN CARTER GRACE CRUMP 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) CRUMP BALTIMORE ST-BALTIMORE, MD. 20e. METHOD OF DISPOSITION
1 ☐ Burtel 2X☐ Cremetion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State Cemetery, crematory or other place) JHH 4 Donetion 5 Other (Specify) 2/4/95 BALTIMORE, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOHNS HOPKINS HOSPITAL 600 N. WOLFE STREET 23. PART I. Enter tha disease, or complicatione that caused tha death. Do not enter the mode of dying, such as cerdiac or raepiratory erreet, Approximate ehock, or heert fellure. List only one cause on each line. interval Between **IMMEDIATE CAUSE (Fine)** Onset and Death disease or condition_ Xtremo immediate recuiting in deeth) ~2 ms Respiratory Severe mmedate Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Diseese or injury QUE TO (OR AS A CONSEQUENCE OF) thet initieted events resulting in deeth) LAST PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 24s. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO OF DEATH? 25.

DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF DEA	TH YES	NO UNCERTAI		☐ YES 2 NO
WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	28. PLAC HOSPITAL: 1 Inpetient 2 ER/Outpatient 3	E OF DEATH (Check		8 Other (Specify)	
MANNER OF DEATH Matural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCURED	
S Suicide 8 Could not be determined	28s. PLACE OF INJURY — At hor building, etc. (Specify)	me, ferm, atraet, 1ec	tory, office	281. LOCATION (Street end Number or Rural Rout City or Town, State)	e Number,
CERTIFIER . CERTIFYING PHYSI	CIAN. To the board of the day				

(Check only one) occurred at the time, data and place, end due to the cause(s) end manner ee stated.

2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(a) and menner ee stated.

29b. SIGNATURE AND TITLE OF CERTIFIER WD	D26728	29d. OATE SI	GNED (Mont	25
TO MAKE AND ACCREC OF DEPOCH WIND COMPLETED BALLS OF THE PARTY OF THE				

Johns Hopkins Hospital, Bultimore, MD Marilee C. Allen, MD

32 REGISTIAN'S EIGNATURE

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

		1 - STATE REGISTRAR		STATE OF I	MARYL					TEALTH DEAT		MENTAL	REG. NO.	E		
		1. OECEDENT'S NAME (First, BABY	Middle, Lest) GIRL	A CF	CIMID							MONTH	OF DEATH		YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHP									95	11:30 A M				
P				1 🗌 M 2 🔀 F			YRS.	MONTHS	DAYS	HOURS 3	MIN.	(Month,	Day, Year)	- 1	Country)	
Pinouls	00	9a. FACILITY NAME (If not ins								OR LOCATIO		ATH	70_+		TY OF DEA	
1, 2, 3	СТОВ	THE JOHNS		S HOSPII	AL				BALT	IMORE	<u>CI</u>	TY_				
Sages	DIRE		10b. COUNTY						OR LOCAT							10d. INSIDE CITY LIMITS?
реглііt. Pages	AL D	MD 10e. STREET AND NUMBER					BAI	LTIMO	ORE,	MD.			_	40- CITI2		1 X YES 2 NO
1Si	ERA	3524 E. BA	ALTIMO	RE STREE	T				100		21224			10g. CI112	USA	IAI COUNTRY?
physician. burial-transit	FUNER	11. MARITAL STATUS 1 Never Married 2		12. WAS DECEOEN FORCES? 1	T EVER IN		0	13.	WAS OEC		F HISPANI	IC ORIGIN	(Specify Yes	or No—	14. RACE -	- American Indian, White, etc.
	BY	3 Widowed 4 Divorce		IF YES, GIVE W					1 TES	2 XNO	Specify:		Con, etc.,		Specify:	
r attending use as the	E E		DENT'S EDUCA highest grade of			16a. DECEO	kind of v	work done		DN ist of workin	<i>a</i>	16b.	KIND OF BUS	INESS/INDU	JSTRY	
0 -	PLET	Elementary/Secondary (0-		College (1-4 or 5	·)	life. Do	NOT us	se retired.)			•					
the hospital detached fo	COMPI	17. FATHER'S NAME (First, Mid	idie, Lasi)			-				18. MOTH	IER'S NAM	AE (First, M	iddle, Maiden	Surname)		
8 E	BE C		CARTER							GF	RACE	С	RUMP			
5 should notified	2	19a. INFORMANT'S NAME (7); GRACE	CRUMP										r, City or Town			21224
ay be		20a. METHOD OF DISPOSITIO	ON .			PLACE AND	DATE	OF OISPOS	SITION (Na		2 214	DATE		ATION - C		
e 6 e		1 Donation 5 Other	Specify)		_ Сете	etery, cremeto HH	ory or o	ther place)			2/	4/95		TIMO		
death. Page 6 m funeral director, i.		21. SIGNATURE OF FUNERAL			~					D ADDRES			m			
2 9 7 8		JOHNS HO								. WOI						
Do it			ert fellure. Li	at only one ceu	se on ee	the deeth	. Do r	ot enter	the mo	de of dyl	ng, such	ss cardi	ec or reapl	ratory erre	et,	Approximete interval Between
fill fill the		immediate cause (Fine disease or condition resulting in death)		EXTRE	ime i	PREMI	ATU	RITY								Onset and Death
Do o le				EXTRO												IMMEDIATE
and o bur	NOI	Sequentially list condition		RT. TE	OR AS A	CONSEQUE	NCE OF	noTrito	RAY							~ 1142
leath certificate be attending physician mtal Hygiene prior to y, or other traur	CERTIFICATION	cause. Enter UNDERLYIN CAUSE (Disesse or Injury	IG	SEVER	E RE	ESPIRA	TOR	TO	ISTR	ES.	3400	DROME				~2 Hes
ding physical displays of the physical display	TIF	that initiated eventa resulting in death) LAST		DUE TO	(OR AS A	CONSEQUE	NCE OF	T):								
- 6 =		DART II Other cleans	d.													
and an	CAL	PART II. Other signiticen	conditiona	contributing to	deeth bu	ut not reeu	ilting-i	n the ur	nderlying	cauee g	iven in P	Part I.	PERFOR		A	WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE
uires ti signed Health DWS an	MEDI											-	1 TYES 2	□ NO	0	OF DEATH?
law require been ept. of ept. of 23 she	N: A	DID TOBACCO US		BUTE TO CA	USE OF	F DEATH	YE	s 🗆 i	NO 🗆	UNC	ERTAIN				'	120 2 100
PHYSICIAN: The law requires the this certificate has been signed with the State Dept. of Health irked, or Item 23 shows an	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO		HOSPITAL:		26. PLACE O		OTHE	R:							
SICIAN certifi th the	HYS	27. MANNER OF DEATH		28a. DATE OF	INJURY		b. TIM	E OF	28c. INJU	9 5 Rec			(Specify)	JURY OCCU	JRED	
DING PHYS After this death with	ВУ Р	1 Netural 5 Pr	ending weetigetion	(Month, Di	ay, Year)		INJ	M		RK? res 2 _	NO NO					
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DIREC DIREC hours	COMPLET	29a. CERTIFIER 1 CERTIF	YING PHYSICI	AN: To the best of	my knowle	edge, death o	occurre	ed at the t	Ime, data	and place.	and due to	o the caus	e(s) and man	ner en stete	4	
HOSPITAL FUNERAL within 72 h	NO.															and manner as stated.
TO THE HOSPITA TO THE FUNERA De filed within 7 IMPORTANT: 1	BE 0	29b. SIGNATURE AND TITLE O	OF CENTIFIED	1						29c. LICE	NSE NUME	BER	T		1	Month, Day, Year)
2 6 3 ₹	2	30. NAME AND ADDRESS OF	PERSON WHD	COMPLETED CAUS	E OF DEA	TH (ITEM 27) /Time	Print)		D49	5991			> 2(5	195	
		30. NAME AND ADDRESS OF I	ccune, M	, C.	OHUS	HOPKI	NS	HOSP	I'ML!	BALTIN	MOSE,	WD :	11287			
		31. DATE FILED (Month, Day, Ye)	g 1995	32. PEGISTRA	R'S SIGNA	N'RANG	14	,								

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I	4. SOCIAL SECU

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE REGISTRAR		STATE OF MARY				F HEALTH AND	MEN	TAL HYGIEN	E			
1. DECEDENT'S NAME (Firs	t, Middle, Last)			-			2. D.	ATE OF DEATH			3. TIME OF DEATH	
An	n	Dorer		Cols	sh		J	inuary 2	8 19	955	7:20 P	M
4. SOCIAL SECURITY NUM			(In yrs. les	MC	F UNDER 1 YEA			ATE OF BIRTH fonth, Day, Year)		6. BIRTH Countr	PLACE (State or Foreign	
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RESIDENCE OF DE		IT ROAD			EA	STON			T	ALB	OT	
10e. STATE	10b. COUNTY			10c. CITY, T	OWN OR LO	CATION					10d. INSIDE CITY LIMITS?	
MARYLAND 10e, STREET AND NUMBER	TALE	BOT		E	ASTO						1 YES 2X NO	
		NIII DOAD				10f. ZIP CODE			'		HAT COUNTRY?	
27479 WE		12. WAS DECEDENT EVER	IN U.S. ARI	MEO	13 WAS (2160 DECENDENT OF HISP		IGIN2 /Canalty Van		USA	- American Indian,	
1 Never Merried 2	Merried	FORCES? 1 YES	2 XN		If yee,	, specify Cuben, Mexi YES 2 X NO Spe	can, Pue	rto Rican, etc.)	01140-	Black	, White, etc.	
3 Widowed 4 Div										Specia	WHITE	
(Specify on	DEDENT'S EDUCA by highest grade of	ATION ompleted)	(G/	CEDENT'S US ve kind of work Do NOT use re	k done durina	ATION most of working		16b. KIND OF BUS	SINESS/IND	USTRY		
Elementary/Secondary (0-12)	College (1-4 or 5+)	100	MEMAK			- 1	OF	M IIO	MTD		
17. FATHER'S NAME (First, A	Aiddle, Last)		I HOL	TEMAK	LK	16. MOTHER'S I	IAME (Fir	rst, Middle, Maiden	N HO	ME		_
J. ROBER	T DORE	R						LLSOPP	Containey			
19e. INFORMANT'S NAME (198	. MAILING AD	ODRESS (Stre	eet and Number or Run			n, State, Zip	Code)		
BARBARA C	. WATK	INS		27479	WES	T POINT	RD	., EAS	TON,	MD	21601	
20e. METHOD OF DISPOSIT				NO DATE OF D		(Neme of	j c	ATE 20c. LO	CATION	City or To	wn, State	
4 ☐ Donation 5 ☐ Other 21. SIGNATURE OF FUNERA		S	ALIS	BURY	CRE	MATORY	1-	30 SA	LISB	URY	MD	
21. SIGNATURE OF FUNERA	IT SEHAICE FICE	NZEE				NAM FUN		I. HOME	p	Α.		
1042						MILL I OIL		n norm				
		ERCERON) (F22	200	S. HAR	RIS	ON ST.	. EA	STO	MD MD	
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EASTON,

MD 21601

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M.D.

32. REGISTRAR'S SIGNATURE
Alla Shucker Randall

BALTIMORE, MARYLAND 21215-0020

ours after death, Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

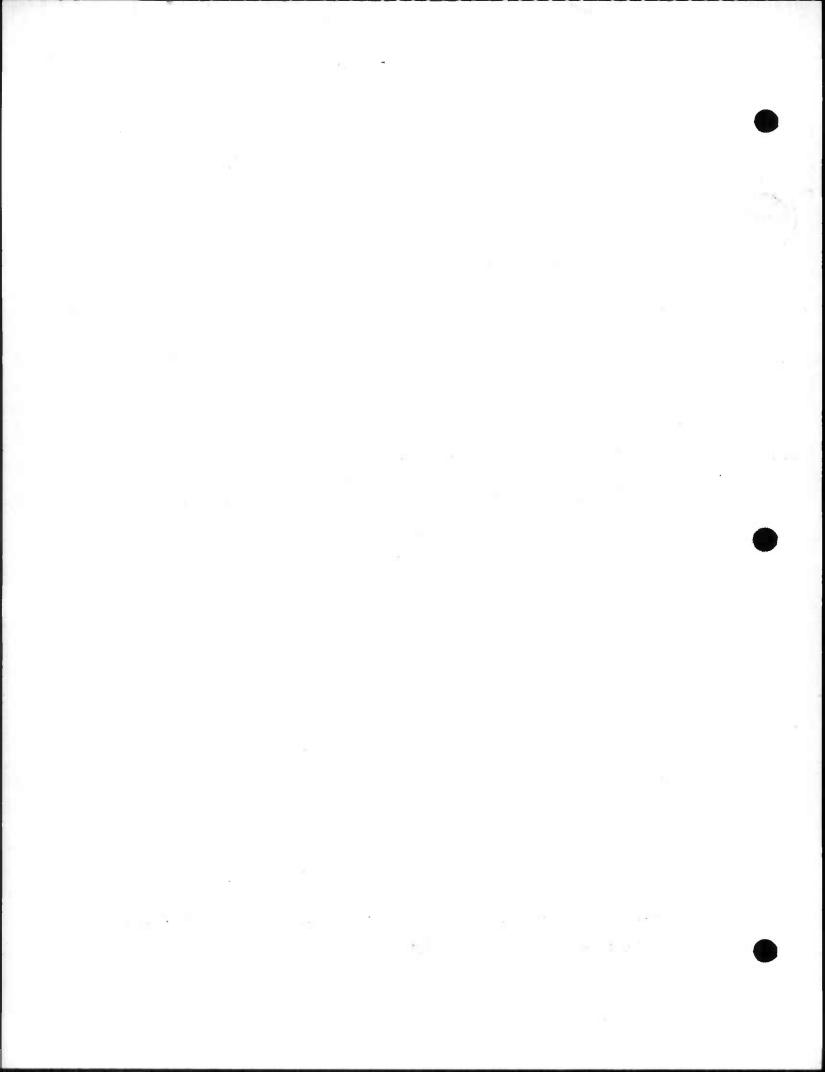
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DAVID

SMITH

JAN 3 n 1995

DHMH-16 Rev 1/89

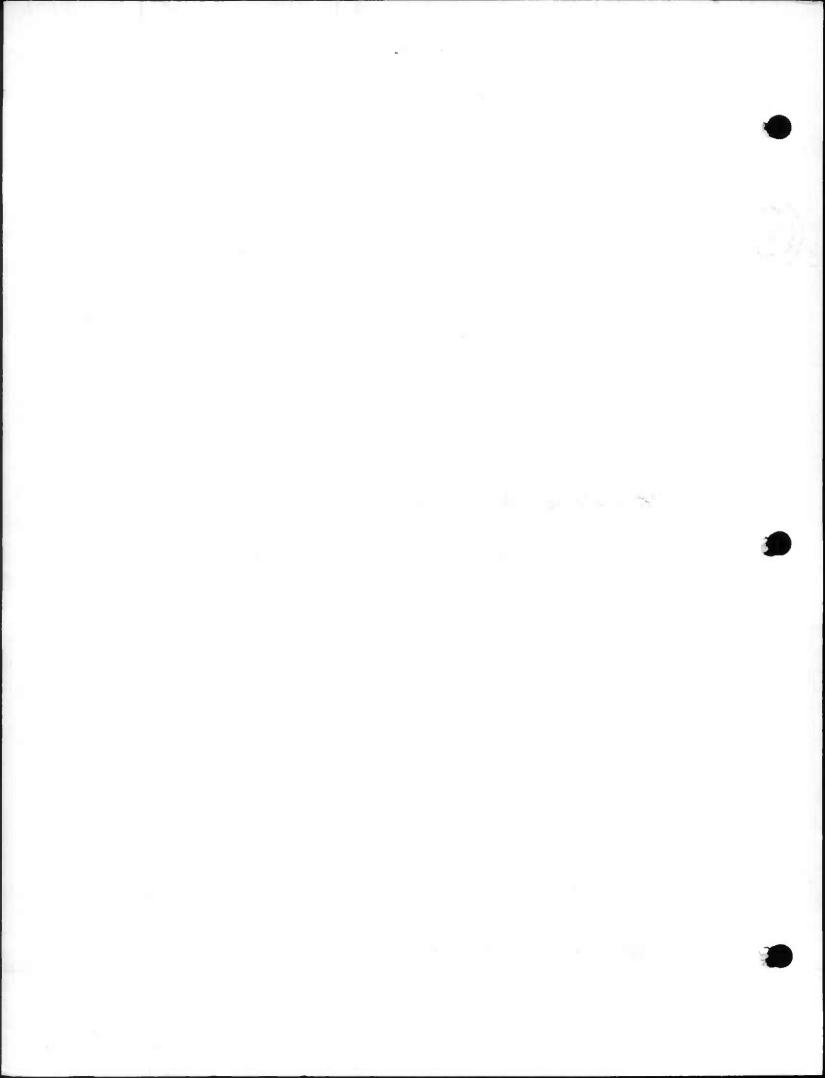


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	FOR 1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF I		MENTA	L HYGIEN	E		
	DECEDENT'S NAME (First, Middle, Last) S	ue G. C	onklin			2. DATE	OF DEATH	1995	YEAR	3. TIME OF DEATH 11:15 A. M
	560-28-3330	1 □ M 2 □XF 78	(In yrs. lest birthdey) YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Oct	of BIRTH h, Day, Year) . 28, 1	916	BIRTHI County On	PLACE (State or Foreign
TOR	90. FACILITY NAME (If not institution, give street William Hill Mano: RESIDENCE OF DECEDENT	· ·		Easto	OR LOCATION OF D	EATH		9c. COUN Talb		EATH
DIRECTOR		lbot		, town on Loca Mi chae l	11-11-					10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	514 Tenant Circle				1. ZIP CODE 21663			U.S		HAT COUNTRY?
B	1 Never Married 2 Merried 3 Wildowed 4 Divorced	2. WAS DECEDENT EVER I FORCES? 1 YYES IF YES, GIVE WAR OR D WIT KOT	2 NO	If yes, sp	CENDENT OF HISPA Hecify Cuben, Mexico 3 2 NO Specific	en, Puerto	17 (Specify Yea Rican, etc.)	or No	14. RACE Black, Specifi	- American Indian, White, etc.
COMPLETED	40	FION impleted) College (1-4 or 5 +)	160. DECEDENT'S USE (Give kind of we life. Do NOT use Register	ork done during mo retired.)	ost of working		KIND OF BUS		ISTRY	
BE COMF	17. FATHER'S NAME (First, Middle, Last) Steve Gesko	x	negistei	ed Nurs	18. MOTHER'S NA	AME (First,				
TO B	190. INFORMANT'S NAME (Type/Print) L'Iarcia A. Rohwede	r			end Number or Rural Circle					o 44122
	20a. METHOD OF DISPOSITION 1	of from State	p. PLACEAND DATE OF metery. cremetory or oth apitol Ci	ematory	Jan. 3	0, 1	995 Do			
	Spruson	Len	aid	Harri 312 S	SON E. I. Talbot	eona St.	St. M	ichae	ls,	e Ma. 21663
	23. PART I. Enter the disease, or corehock, or heart fellure. List IMMEDIATE CAUSE (Final disease or condition resulting in death)	Mpg.	d the death. Do not dech line.					ratory arre	et,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		A CONSEQUENCE OF)							
MEDICAL	PART II. Other eignificent conditions	contributing to deeth b	out not resulting in	the underlying	g ceuse given in	Part I.	24a. WAS AN A PERFORI	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:		IOSPITAL:		26. PI ОДНЕЯ:	ACE OF DEATH (Ch	eck only on	ю)			
	27. MANNER OF DEATH 1 🔀 Netural 5 🗌 Pending	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME	OF 28c. INJ	URY AT PRK?		r (Specify) CRIBE HOW IN	JURY OCCU	JRED	
TED BY	2 Accident Investigation 3 Suicide e Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, str			201. LOC City	ATION (Street er or Town, Stete)	nd Number o	r Rural Ro	oute Number,
COMPLETED	29e. CERTIFIER (Check only one) 1 M CERTIFYING PHYSICIA 2 MEDICAL EXAMINER:									end menner ee stated.
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	Cager)		29c. LICENSE NUI	MBER (Z-2	2.5	29d. DATE	signed (Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO C	arney M.D.	509 Id1	·	ve. East	on, i	/iarylar	nd	2166	01
1	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE.							

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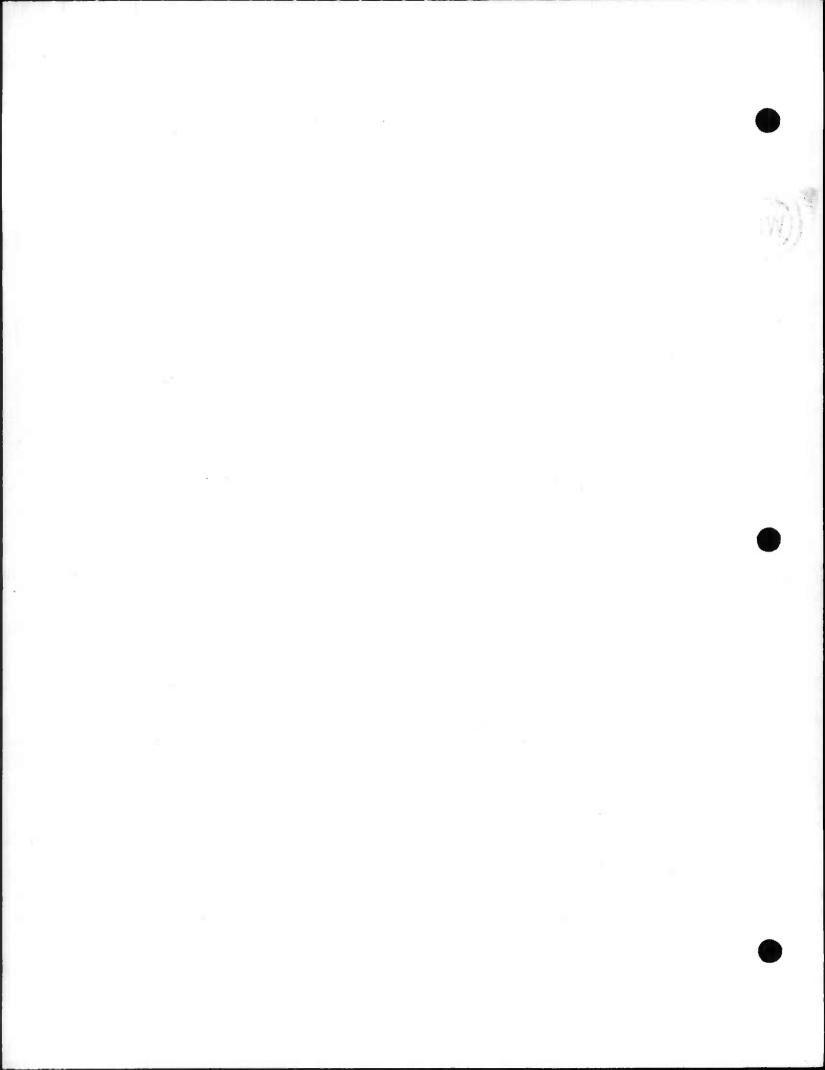
32. REGISTRAR'S SIGNATURE.



BALTIMORE, MARYLAND 21215-00	24 hours after death. Page 6 may be retained by the hospital or attending p	filled in by the funeral director, page 5 should be detached for use as the lon, or removal.	he medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2x hours after death. Page 6 may be retained by the hospital or attending p	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR		CERTIF	CATE C	F DEATH	REC	S. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) LASKO Lasko	off	ZHAM	1BE	PLAIN	2. DATE OF OE	ATN DAY 29	YEAR 95	3. TIME OF DEATH 04/15 Am
	102–14–7878	X M 2 □ F 79	rrs. lest birthday) YRS,	IF UNDER 1 YEAR		7. DATE OF BIRT (Month, Day,) Aug/2/1	TN	a. BIRTNP Country) Engla	
DIRECTOR	Suburban Hospital	end number)		Bethes	N OR LOCATION OF DEA		9c. CO	UNTY OF DE	ATH
5	RESIDENCE OF DECEDENT							aregor.	ica, y
2	10a. STATE 10b. COUNTY			, TOWN OR LO	CATION				10d. INSIDE CITY LIMITS?
	MD Montgo	mery	Rock	ville					1 TYES 2 XNO
FUNERAL	5901 Montrose Road	l			107. ZIP CODE 20852		USA		HAT COUNTRY?
B≼	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	P. WAS DECEDENT EVER IN U. FORCES? 1 (X) YES : IF YES, GIVE WAR OR DATE WWIII	2 NO	If yes,	DECENDENT OF NISPANIC specify Cuban, Mexican, res 2 NO Specify:	ORIGIN? (Spec Puerto Rican, e	Ify Yes or No-	14. RACE - Black,	— American Indian, White, etc.
	15. DECEDENT'S EDUCATI (Specify only highest grade com-	ION 16	e. DECEDENT'S	USUAL OCCUP	ATION	16b, KIND (OF BUSINESS/IN	DUSTRY	
Щ		College (1-4 or 5+)	Iffe. Do NOT use	ork done during a ratired.)	most of working				
COMPLETED			Biochen	nist			chemist	ry	
ш	17. FATNER'S NAME (First, Middle, Last) Not Available Ka	igan			Frieda	Not Av	Maiden Surmerne) Vailabl	.e	
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Stre	et end Number or Rural Ro	ute Number, City	or Town, State, Z	ip Code)	
-	Lois Chamberlain		5901	Montro	se Road/Ro	ckville	e/MD/20	852	
	20e. METHOD OF DISPOSITION 1 ☐ Burlel 2 ⚠ Cremation 3 ☐ Removal	20b. PL	ACEANDDATEO	FDISPOSITION			Oc. LOCATION -		n, State
-	4 Donation 5 Other (Specify)	Met	ry, crematory or ott	tan Cre	ematory	1/31	Alexand	dria V	'A
. 1	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE C			ANO ADDRESS OF FACI				
	Melanus Nell	relacion Vacor	سعا	Ann	ent Memoria apolis MD :	21401			
	23. PART i. Enter the diseases, or com shock, or heart failure. List	picetions thet caused the	ne death. Do n	ot enter the	mode of dying, auch	ss cerdiac or	reapiretory a	rrest,	Approximata interval Between
	IMMEDIATE CAUSE (Fine)	1 (11	P 11	0		1 1			Onset and Death
	disease or condition resulting in death)	DUE TO (OR AS A CO	all (aru	nomen o	Alu	12		8 months
		DUE TO (OR AS A CO	INSEQUENCE OF):	l.	2	0		
CERTIFICATION	Sequentisity list conditions, if sny, lesding to immediate	OUE TO (OR AS A CO	INSEQUENCE OF):					
CA	CAUSE (Disease or injury								
	that initisted events resulting in death) LAST	OUE TO (OR AS A CO	INSEQUENCE OF):					
#	d.								
	PART II. Other significent conditions of	ontributing to death but	not resulting in	the underly	ring cause given in Pr	nrt i. 24a. W	AS AN AUTOPSY	24b. Y	WERE AUTOPSY FINDINGS
EDICAL	Chronic arrev	dus Obstu	udere	Ris	case		ERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
	Cardine Com	aly arter	in	riare	/	_ ''''	ES 2 MU		OF OEATH?
Σ.	DID TOBACCO USE CONTRIB	LITE TO CAUSE OF I		S NO	UNCERTAIN			'	1 NES 2 NO
₹ I	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEAT						
PHYSICIAN:		OSPITAL: Inpatient 2 - ER/Outpatie	ont 3 DOA	OTHER:	ama & C Baddaaa A				
Ĭ	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME		oma 5 Reeldence 6		NOW INJURY OC	CUREO	
ВУ Р	1 Natural 5 Pending	(Month, Day, Year)	INJU	IRY	WORK?			JOHLO	
	3 Suicide a Could not be	28e. PLACE OF INJURY — building, etc. (Specify)	At home, ferm, st	reet, factory, o	Mice 2	eff. LOCATION (S City or Town,	Street and Number	or or Rural Ro	ute Number,
COMPLETED	4 Homicide determined								
MPL	(Check only	N: To the best of my knowledg							
8	2 MEDICAL EXAMINER: 0	n the beele of examination en	id/or investigation	, in my opinior	, death occured at the tir	na, date end ple	ce, end due to t	he ceuse(a) a	and manner as stated.
BE (296 SIGNATURE AND THEY OF CHITIFIER				29c. LICENSE NUMB	ER	29d. DAT	TE SIGNED (Month, Day, Year)
0	MATHER ME	FLUP.			D0706	7	> /	129/	25
	EDWARD S MEHLM	OMPLETEO CAUSE OF DEATH 5625			EVAND B	ETHESM	A 20	814	
	31. DATE FILEO (Month, Day, Year)	12. REGISTRAR'S SIGNATU	RE O	-40	711 - 17	-111110	//		
	FEB 0% 198	Delia d'ave	dear Ford	щ.		ı)

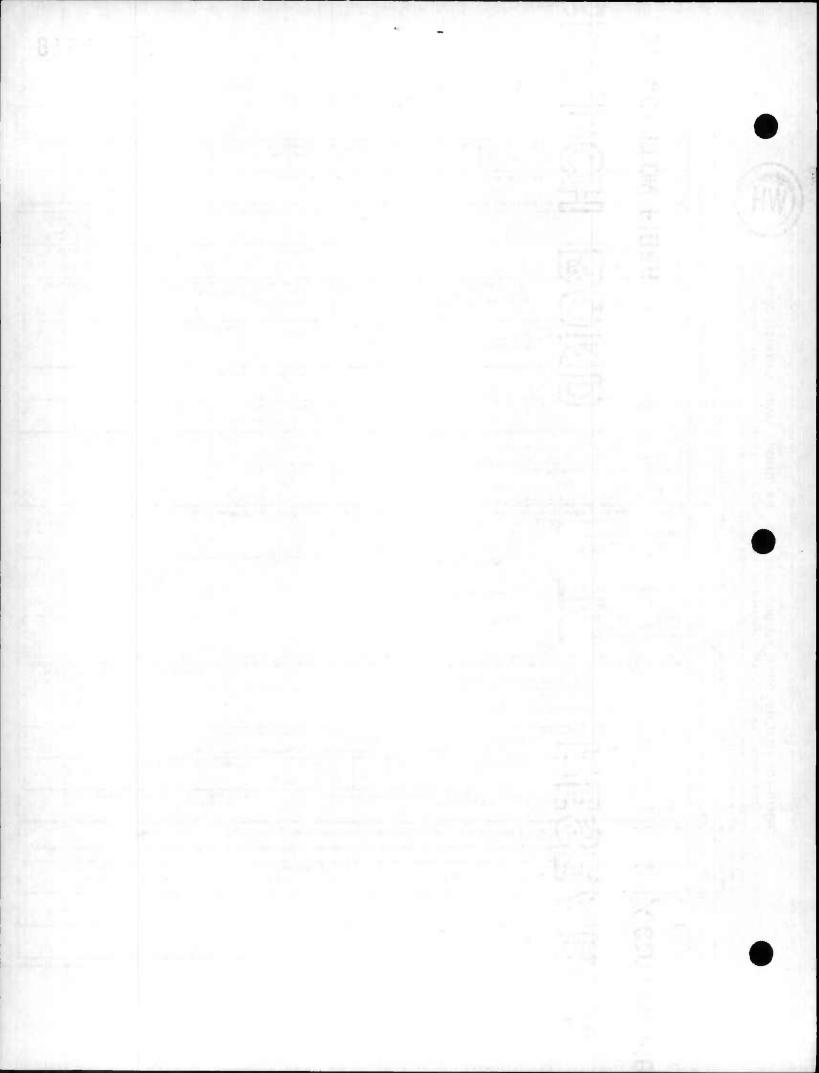


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Jours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. It is not can be set of the state Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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	1 - STATE REGISTRAR	STATE OF M	IARYLAND / DEI CERT	PARTMEN			D MEN	TAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last) Betty Jane	Carter					M	ATE OF DEATH DATE OF DATE OF DEATH DATE OF DATE OF DEATH DATE OF		95	3. TIME OF DEATH 5:00 A M
	4. SOCIAL SECURITY NUMBER 212-20-9537	5. SEX 1 M 2 F	6. AGE (In yrs. last birthe	MONTHS	DAYS	IF UNDER 24 HR	Ju	ATE OF BIRTH Month, Day, Year, Ne 10,19	925	a. BIRTH Country NOT	th Carolina
TOR	9a. FACILITY NAME (If not institution, give 14755 Frederick RESIDENCE OF DECEDENT			100	y, town of Cooksy	LOCATION OF	DEATH		100	NTY OF DI	
DIRECTOR	10e. STATE 10b, COUNT	n Howard	10c.	COOKS	OR LOCATE						10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 14755 Frederick 1	Road			101.	21723					THAT COUNTRY? States
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		T EVER IN U.S. ARMED YES 2 NO AR OR DATES	13.	WAS DECE If yes, spec 1 YES 2	ify Cuban, Mai	rican, Pu	RIGIN? (Specify Yes orto Rican, atc.)	or No-	14. RACE Black Speck	- American Indian, Whita, etc.
COMPLETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12) 1.2	UCATION le completed) Collège (1-4 or 5+) life. Do N	NT'S USUAL Of d of work done OT use retired.) Memake	during most	of working		16b. KIND OF BUS	Home		
BE CO	17. FATHER'S NAME (First, Middle, Last) William T. Ralp	oh				Emi.	ly	ist, Middle, Maiden V. Farl	Ley		
10	19a. INFORMANT'S NAME (Type/Print) Don Stoppenbach		441	6 Ring	ggold	Lane 1	Plan	Number, City or Town a Texas	7509	3	
	20a. METHOD Q5 DISPOSITION 1		20b. PLACE AND D. carnetery, crametory, BALTLIMO	re-Was	hing	ton Cr	em F	eb7 Lau	rel,		yland
	+ Harry	H. Wi	the	4	4112	old Co.	lumb		Elli	.cott	City 21043
	23. PART I. Enter the disease or shock, or heart failers immediate CAUSE (Final disease or condition resulting in desth)	a	con each line.	nq	r the mod	a of dying, a	uch aa	cardiac or reapi	retory ar	reat,	Approximete interval Batween Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	b	(OR AS A CONSEQUENC								
ERTIFI	that initiated eventa resulting in deeth) LAST	d.	(OR AS A CONSEQUENC	CE OF):							
MEDICAL	PART II. Other algorificant condition	na contributing to		ing in the u	ndarlying	cause given	in Part	I. 24a. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 ANO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHE	_	CE OF OEATH	(Check or	ly one)			
BY PHYS	1 YES 2 NO 27. MANNER OF OEATH 1 Netural 5 Pending 2 Accident Investigation	1 inpatient 2 2 28e. OATE OF (Month, Da	ER/Outpatient 3 DC INJURY 28b. sy, Year)	TIME OF INJURY	28c. INJUI WOR	5 A Aesiden RY AT K7 S 2 NO		Other (Specify) OESCRIBE HOW II	NJURY OC	CUREO	
	2 Accident Investigation 3 Suicide 6 Could not be determined	28a. PLACE DE building,	F INJURY — At home, fa atc. (Specify)	rm, street, fac	ctory, office		281,	LOCATION (Street a City or Town, State)	and Number	r or Rural R	oute Number,
COMPLETED			my knowledge, death oc amination and/or investi								and manner as stated.
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIE	- Luc	mo			29c. LICENSE D 2 3 4				E SIGNED	(Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON W	MAYO	, 100 16	Type, Print)	Freder	riele A	e o d	4213	60.1	beri b	11, 00
	31. DATE FILED (Month, Day, Year)		R'S SIGNATURE	4							



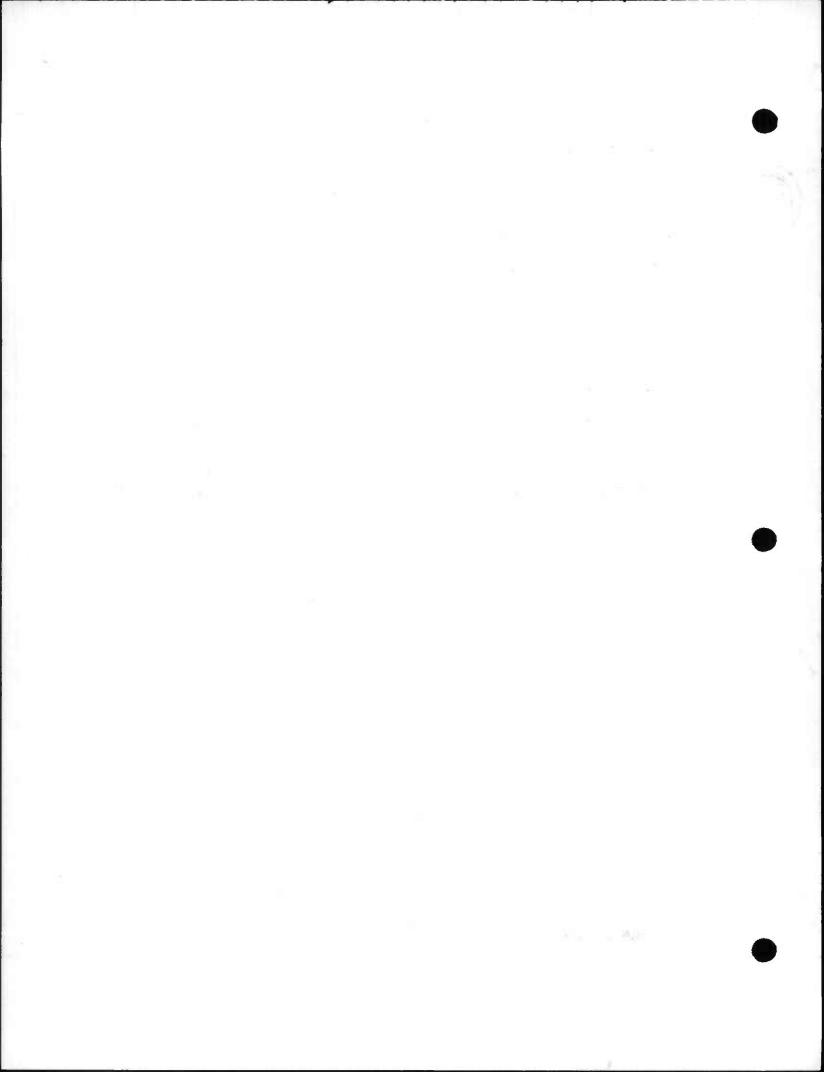
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Flours with death, Prop 6 may be intained by the intending physician and completely filled in by the function page 5 should be detached for use as the burnishment to be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remove

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	(CERTIFIC	ATE OF	DEATH	REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH \(\Omega\).
	Albert KANNO.	the Con	200		= 1	MONTH DA		195 200 M
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs	lant highelant II	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	- 1	B. BIRTHPLACE (State or Foreign
	166-12-403			NTHE DAYS	HOURS MIN.	(Month, Day, Year)		Country)
	33-234-4031	/3	7.3%			Mar. 28,1		Pennsylvania
_	9a. FACILITY NAME (If not institution, give street and i	number)	91	CITY, TOWN C	R LOCATION OF DE	ATH	9c. COUNT	Y OF DEATH
DIRECTOR	Fallston General Hos	spital		Falls	ston		Ha	arford
5	RESIDENCE OF DECEDENT							
H	10a. STATE 10b. COUNTY		10c. CITY, To	OWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?
	Maryland Harfo	ord	E	dgewood	E			1 TYES 2XXNO
A	10e. STREET AND NUMBER			10f	ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?
E	2515 Willoughby Bead	ch Road			21040		11.9	S.A.
FUNERAL	11. MARITAL STATUS 12. WAS	S DECEDENT EVER IN U.S.		13. WAS DEC		IC ORIGIN? (Specify Yes		4. RACE — American Indian.
Œ,		RCES? 1 X YES 2 [YES, GIVE WAR OR DATES	NO	If yes, spi	2 XNO Specify:	i, Puarto Rican, etc.)		Black, White, atc.
BY	9 Widowed 4 Diseased	II		I I I TES	2 KNO Specify:			Specify: White
0	15. DECEDENT'S EDUCATION	16a.	DECEDENT'S US	IAL OCCUPATION	IN .	16b. KIND OF BUS	INESS/INDUS	
E	(Specify only highest grade completed Elementary/Secondary (0-12) Cotlege		(Give kind of work life. Do NOT use re	done during mo- tired.)	st of working			,,,,,
2	E 2007 2010 00 00 00 00 00 00 00 00 00 00 00 00	e (1-4 or 5 +)	D		0			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		avv Equ	Ipment	Operator			1
ŏ						AE (First, Middle, Maiden	Surname)	
BE	Fred A. Cooper					na Guyton		
2	19a. INFORMANT'S NAME (Type/Print)					oute Number, City or Town		ode)
77	Albert K. Cooper, Ji	<u>c.</u>	723 S	equoia	Drive, E	Edgewood, 1	MD 21	1040
	20a. METHOD OF DISPOSITION 1 ☑ Burlei 2 ☐ Cremation 3 ☐ Removal from		EAND DATE OF D		me of	DATE 20c. LOC	CATION — CH	ty or Town, Stata
	4 Donation 5 Other (Specify)	Bel	Air Me	morial	Gardens		Air,	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE			22. NAME AN	D ADDRESS OF FAC	Funeral H	omo T	2 7
	► Manual Wish	4						
\dashv	23. PART I. Enter the diseases, or complica	Lovanni .	death the said			land 2100		
- 1	shock, or haart failura. Liat only	y ona cause on each if	ne.	antar the mo-	da of dying, auch	aa cardiac or reapi	ratory arres	st, Approximata interval Batween
	IMMEDIATE CAUSE (Finel	NC noce	The r	140		7	11	Onset and Death
ļ	disease or condition reaulting in death)	NCANCEN		TER	NIAW	14/1VB	a-Don	nina) days
	N. C. C. C. C. C. C. C. C. C. C. C. C. C.	DUE TO (OR AS A CONS	SEOUENCE OF):					
z	D	Jenis						
吕	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A CONS	SEQUENCE OF):					
5	CAUSE (Disease or Injury							
	that initieted events	DUE TO (OR AS A CONS	SEQUENCE OF):					
CERTIFICATION	resulting in death) LAST							
_	PART II. Other algolificant conditions contri	husten so death but an	A					
8		when a (cause given in i	Pert I. 24s. WAS AN . PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	COCMIS GLAC	Wed Get	- 1 ocev	4		1 YES 2	NID	OF DEATH?
M						_ / (1 TES 2 NO
ż	DID TOBACCO USE CONTRIBUTE	TO CAUSE OF DE	ATH YES		UNCERTAIN			
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		ACE OF DEATH (
<u> </u>	- Cost	PITAL: patient 2 - ER/Outpatient		HER: Nursing Home	5 Rasidence	B ☐ Other (Specify)		
PH	27. MANNER OF DEATH 284	B. DATE OF INJURY	28b. TIME OF	28c. INJ	JRY AT	29st. DESCRIBE HOW IN	JUNY OCCU	RED
	y Natural 5 Pending	(Month, Deg. Mar)	INJURY		ES 2 NO			
BY	2 Accident Investigation 28st	. PLACE OF INJURY - At	home, farm, stree			29f. LOCATION (Street a	nd Number or	(River) Dructe Niverbur
9	4 Homicide B Could not be	building, etc. (Specify)		(())		City or Youn, State)		
	29a, CERTIFIER							
COMPLE	(Check any POEMTIFTING PHYSICIAN: 18 1							
5	E IZI MEDICAL EXAMINER ON THE	beats of auditination and/o	er Investigation, Ir	my opinion, de	inth occurred at the t	line, date and place, and	due to the i	cause(s) and manner as stated.
u I	296. SIGNACTIVE AND TYPE OF CERTIFIER	, ()			29c. LICENSE NUM	men	20d. DATE I	DIGNED (Month, Day, War)
2 2	(ywde va	1.00			D283	39	nu	Loun 25 1995
=	30. NAME AND ADDRESS OF PERSON WHO COMPL	ETED CAUSE OF DEATH (F	TEM 27) (Type: Pro-	7 0 1	7	20,0	1	
	LINDA FUE 1411	H (01)	Such	eel f	orio t	seller	102	10/1
	" JAN 27 1995 Jes	negetenedison-dison	dall					



TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - FOR STATE REGISTRAR		STATE OF I	MARYLAN	D / DEPAI CERTIF					MENT	TAL HYGIEN			
1. DECEDENT'S NAME (First	Middle, Last)				-				2. D/	TE OF DEATH			3. TIME OF DEATH
Margai	rot	Gert	rude		COL	BLEN'	T7		MO	NTH D	Ž, 19	95	8:45pm
4. SOCIAL SECURITY NUMBER		5. SEX		rs. lasi birthday)	1	ER 1 YEAR	_	R 24 HRS.	_	TE OF BIRTH	/ , 1:		PLACE (State or Foreign
225-52-714		1 🗌 M 2 💢 F	89		MONTHS	7	HOURS	MIN.	CM	c 7, 19	05	Countr	nsylvania
9a. FACILITY NAME (If not in						TY, TOWN			EATN			NTY OF D	
Meridian 1		g Center				$\operatorname{Fred}\epsilon$	erick	C			Fr	eder	ick
RESIDENCE OF DEC													
Maryland	Fred	lerick				rick	ION						10d. INSIDE CITY LIMITS? 1 X YES 2 NO
10e. STREET AND NUMBER						101	ZIP COD	DE			10g. CIT	IZEN OF W	VHAT COUNTRY?
411 Culler	Avenue						21	701				U.S.	Α.
11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN U.	S. ARMED	1;	. WAS DEC	ENDENT (OF NISPAN	IIC ORI	GIN? (Specify Yes	or No.	14 BACE	— American Indian,
1 Never Married 2 🛣	Married	FORCES? 1				If yes, sp	ecify Cubi	en, Mexice	n, Puer	to Rican, atc.)		Black	t, White, atc.
3 Widowed 4 Divo	rced	# 125, GIVE V	WAN ON DATE.	3		1 TYES	Z K NO	Specify	y:			Speci	" White
15. DEC	EDENT'S EDU	CATION	16	a. DECEDENT'S	USUAL	OCCUPATION	ON			16b. KIND OF BU	SINESS/IN	DUSTRY	
(Specify onle	highest grade			(Give kind of life. Do NOT u	work don	e during mo	st of worki	ing					
10	-12)	College (1-4 or 5	"	Hor	nema	ker					Own 1	Home	
17. FATHER'S NAME (First, M	iddle Lesti			1101	iiciia	RCL	40 1107	ALEDIO ALA	WE (E)			TOILC	
William		mas	Harri	cr.				da	ME (FIR	t, Middle, Meiden May		orb	
19a. INFORMANT'S NAME (7		illas	narrr										
Mr. Charles	,, , .	hlonts	Cm							umber, City or Tow			21701
		brentz,	PL	411 (JULL	er A	venue	е, г	rea	erick,	mary.	land	21701
20a. METNOD OF DISPOSIT. Ty□ Buriel 2 □ Crematic 4 □ Donation 8 □ Other	n 3 🗆 Remo	oval from State	cemeter	y, cremetory or c	ther plec	oi		v Fel	1	100		city or To erick	wn, State c, Maryland
21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE		OTHER DESIGNATION	22	2. NAME A	D ADDRE	SS OF FA	CILITY				
Ketth hy	nank	berser	_ N	100706						P.A. Fu			me D 21701
23. PART I. Enter the di	sesses, or o	omplications the	t caused th	e death. Do	not ente	er the mo	de of dy	ing, suci	h ss c	ardiac or respi	ratory sr	rest,	Approximate
shock, or he IMMEDIATE CAUSE (Fir		List only one cau	ise on each	line.				1					Onset and Death
disesse or condition	lan	(1	1 M	0.7	Kr	Hu	1-	*	4	eage			1 1 2 1 DE
resulting in death)	7	DUE TO	(OR AS A CO	NSEQUENCE O	(C)	1 - 00	-			Contract of the	-		years
		332 13	(011 AD A 00	/ Index of	·).	(/
Sequentially list conditi	ona,	DUE TO	(OB AS A CO	NSEOUENCE O		_	/						
If sny, leading to Imme- csuse. Enter UNDERLY!		502.10	(On AS A CO	NSECUENCE U	·r):								i
CAUSE (Disease or Inju		C. DUE TO	(OD 40 4 00	NSEQUENCE O									_
that initiated events resulting in death) LAS		DOE TO	(OH AS A CO	NSEQUENCE O	(F):								
		1											
PART II. Other significa	nt condition	s contributing to	death but	not reaulting	in the s	ınderivine	cause	given in	Part I	24a. WAS AN	VPGOTUA	24b	WERE AUTOPSY FINDINGS
		-				,,,,,	100000	3		PERFOR		1240.	AVAILABLE PRIOR TO
									_	1 TYES 2	NO		DF DEATH?
													1 TYES 2 NO
DID TOBACCO U		RIBUTE TO CA	USE OF E	DEATH Y	ES 🔲	NO 🔽	UNC	CERTAIN	4 🗆				
25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26.	PLACE OF DEA		_							
1 TYES 2 NO		1 Inpatient 2	ER/Outpatle	nt 3 🗆 DOA	OTHE 4 N		• 5 🗆 R	esidence	6 🗆 O	ther (Specify)			
27. MANNER OF DEATN		26e. DATE OF (Month, D		26b. TIN	IE OF JURY	26c. INJ	URY AT		26d. [DESCRIBE HOW I	NJURY OC	CURED	
	Pending investigation	I WOMIN, D	-7. rom/		M		ES 2	□ NO					
a College	Could not be	26a. PLACE C	F INJURY -	At home, farm,	streel, la	ctory, offic			281. L	OCATION (Street &	nd Numbe	r or Rural R	loute Number,
	determined	building,	atc. (Specify)						C	ity or Town, State)			

CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, end due to the cause(s) and menner on stated.

29c. LICENSE NUMBER

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

BALTIMORE, MARYLAND 21215-0020

TO THE FUNERAL ORECTOR: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 5 should be detached for use as the bunal-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Il item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

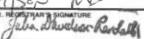
2

29a. CERTIFIER (Check only one)

30. NAB

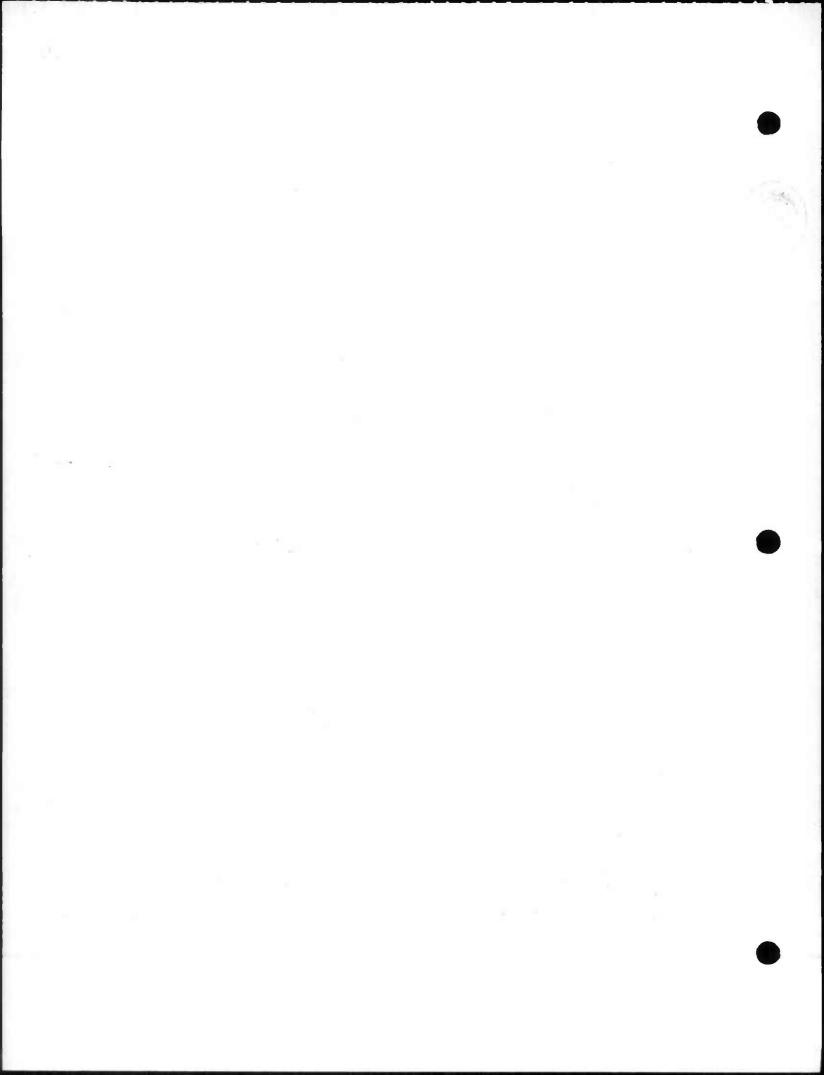
TO THE HOSPITAL OR ATTENOING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.

31. DATE FILED (Month, Da Ó



MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time,

29d. DATE SIGNED (Month, Day, Year)



FOR

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR		CE	RTIF	CATE O	F DEAT	Ή		REG. NO.			
1. DECEDENT'S NAME (First, Middle, La	ist)		_				2. DATE	OF DEATH			3. TIME OF DEATH
TOHN	ANTHONY		CRA	mmvz			MONTH	IIARY 4		YEAR 195	1701 M
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest t		IF UNDER 1 YEAR	IF UNDER	24 HRS.	7. DATE (OF BIRTH		8. BIRTH	IPLACE (State or Foreign
218 38 6424	1 € M 2 □ F	56	YRS.	MONTHS DAYE	HOURS	MIN.	Decent Decent	ber 10,	1938	Mary	land
9a. FACILITY NAME (If not institution, gi	ve street and number)			9b. CITY, TOWI	OR LOCATIO	N OF DE				NTY OF D	
CALVERT MEMORIA	T HOCDIMAT										
RESIDENCE OF DECEDENT	L HOSPITAL	-		PRINCE	FRED	ERIC	K		CAL	VERT	
10e. STATE 10b. COU Maryland Calv			SOLO	, TOWN OR LOC	ATION						10d. INSIDE CITY
Maryland Calv	erc		Sulu	us							LIMITS?
100. STREET AND NUMBER 13325 Dowell Road					101. ZIP CODE 20688				100 CIT	ZEN SE	WHAT COUNTRY?
11. MARITAL STATUS	12 WE DECEDE	IT EVER IN U.S. ARMI	-	1 10 11110 0							
15 Nover Merried 2 Merried	FORCES? 1	YES 2 NO)	If yes,	specify Cubar	F HISPAN 1, Mexicer	n, Puerto R	? (Specify Yes lican, etc.)	or No-	Black	E — American Indien, k, White, atc.
3 Widowed 4 Divorced	IF YES, GIVE V	MAR OR DATES		1 🗆 Y	ES 2 X NO	Specify				Speci	"white
15. DECEDENT'S E	DUCATION	18a, DECE	EDENT'S	USUAL OCCUPA	TION		165	KIND OF BUS	INECC/IN		
(Specify only highest gr Elementary/Secondary (0-12)		(Give	e kind of w Do NOT us	rock done during	nost of working	g	100.		WITE 33/1146	JU31111	
12	College (1-4 or 5		ver w				1	n/a			
17. FATHER'S NAME (Flist, Middle, Last) Benjamin Cratty Sr.					16. МОТН	ER'S NAI	ME (First, M	fiddle, Maiden S	Surname)		
19a. INFORMANT'S NAME (Type/Print)		19b.	MAILING	ADDRESS (Street	t and Number	or Rural R	loute Numb	er, City or Town	, State, Zip	Code)	
Charles Cratty		301	17 Ge	orgia Av	e. Balt	iore,	Mary.	land 212	227		
20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 R	lemoval from State	20b. PLACE AN cemetery, cremi		F DISPOSITION		0.4	OATE	20c. LOC	CATION —	City or To	wn, State
4 Donation 6 Other (Specify)		St Man	v ¹ s o	f the Mi	egnar	y 9,1	995	_ taure	l P.G	Man	vland
21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	1	7	22. NAME	AND ADDRES	S OF FAC	Ra	usch Fu	reral	Home	
· BRC	اللص	/		4405 1	Broones	Is.	Rd. P	art Rep	ublic	Mary.	land 20676
23. PART I. Enter the diseases, i	or complications the	t caused the deat	th Do n	- 4 4 4				lee or recal			
	re. List only one cau	ise on each line	tii. DO 15	ot enter tha n	noda of dyla	ng, such	as card	iac or reapir	ratory an	rest,	Approximate
IMMEDIATE CAUSE (Finel	re. List only one cau	use on aach line.	ui. 50 ii	ot enter tha n	noda of dyli	ng, such	n as card	iac or reapir	ratory an	rest,	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition		use on aach line.	enh	ot enter than	noda of dyli	ng, such	n as card	iac or reapir	ratory an	rest,	Intarval Between
IMMEDIATE CAUSE (Finel	·. P	OR AS A CONSEQU	enh	ot enter than	noda of dyli	ng, such	n as card	lac or reapir	ratory an	rest,	Intarval Between
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hours after death. Page 6 may be retained by the hospital or attending physician.

BALTIMORE, MARYLAND 21215-0020 THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

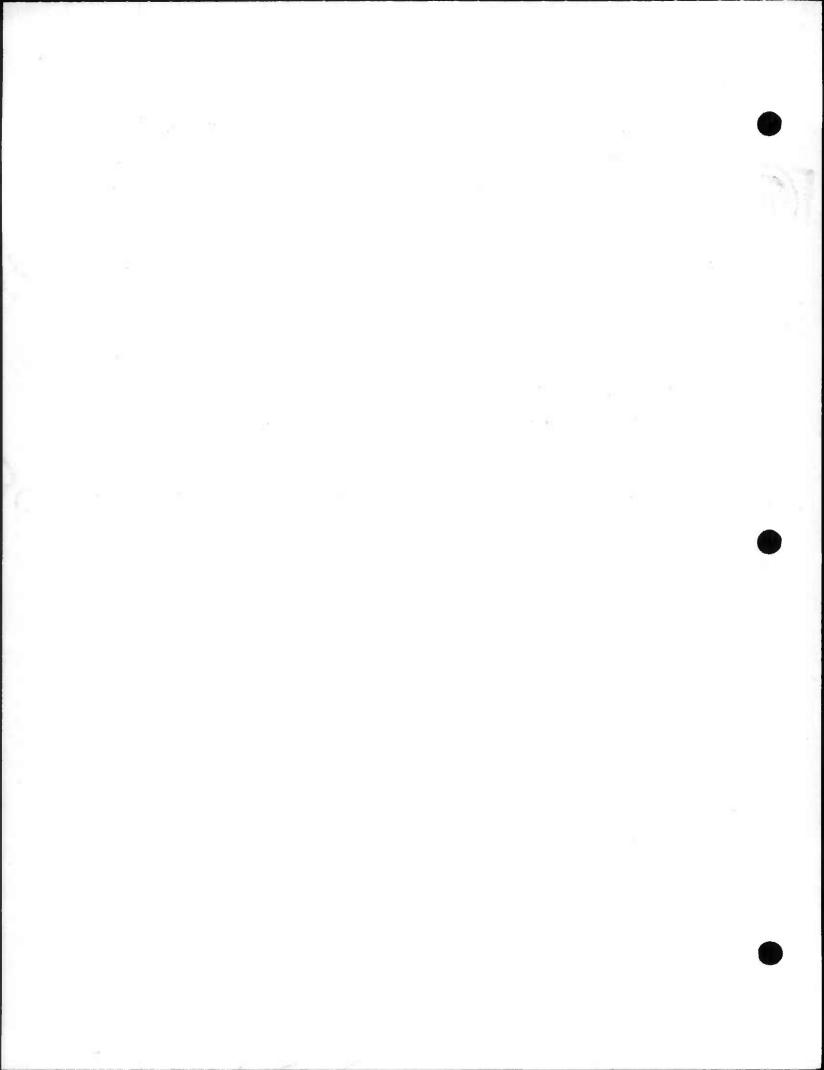
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit is be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR		CERT	IFICA	TE OF	DEATH		REG. NO			
1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF				3. TIME OF DEATN
ESTHER	G.	CHISS				JANUA	RY 2		95	4:10 P.
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birtho	day) IF U	NDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTH	1		PLACE (State or Foreign
577-30-7982	1 🗆 M 2 🔀 F	83 YF	21		HOURS MIN.	AUG.			RU	SSIA
HEBREW HOME OF G. RESIDENCE OF DECEMENT 10a. STATE MARYLAND WARYLAND WARYLAND WARYLAND HEBREW HOME OF G. RESIDENCE OF DECEMENT 10b. COUNT MARYLAND PRI		SHINGTON	96.		OR LOCATION OF D	DEATN			TGOM	
10e. STATE 10b. COUNT	Υ	10c.	CITY, TOY	VN OR LOCA	TION					10d. INSIDE CITY
	NCE GEORG			LPHI	32.0					LIMITS?
10e. STREET AND NUMBER 8426 20TH AVENUE 11. MARITAL STATUS 1 Never Married 2 Married				10	20783					STATES
3 Widowed 4 Divorced		TEVER IN U.S. ARMED YES 2 X NO AR OR DATES		If yes, sp	CENDENT OF HISPA Hecity Cuban, Mexic 2 X NO Speci	an, Puerto Ric	Specify Yes	or No-	14. RACE Black Specifi	— American Indian, White, etc.
15. DECEDENT'S EDU (Specify only highest grade (Specify only highest grade 12 12 17. FATHER'S NAME (First, Middle, Last)	o completed)	life Do Ali	T'S USUA d of work di OT use retin	one during me	ON ost of working	16b. K	IND OF BU	SINESS/IND	USTRY	
Elementary/Secondary (0-12)	College (1-4 or 5 +)		ARY C	LERK	FE	DERA	L GOV	ERNM	ENT
	CKA				18. MOTHER'S NA					
19a INFORMANT'S NAME (Type/Print)	JK1	105 4441	INC ADD	F00 (0)			NOWN	·		
	SON)				ENUE, AD			n, State, Zip 2078		
20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Rem 4 Denation 5 Other (Specify)	noval from State 1	20b. PLACE AND DA	ATE OF DIS	POSITION (N.	ama ol	1/30	20c. LO	CATION	City or Ton	,
21. SIGNATURE OF FUNERAL SERVICE LI	GENSEE /	MI. LED		22. NAME A	ND ADDRESS OF FA	ACILITY				RYLAND
> Thee	7 1				NSKY-GOL ROCKVILL					ELS, INC. MD 20852
Sequentially list conditions, if sm, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO	OR AS A CONSEQUENC	E OF):	ERUS						Onset and Death
that initiated events resulting in death) LAST	DUE 10	OR AS A CONSEQUENC	E OF):							
PART II. Other significant condition	ns contributing to	death but not resulti	ing in the	underlyin	g cause given in		PERFOR	MED?		WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATN	RIBUTE TO CA	USE OF DEATH	YES [1 NO4[2	UNCERTAI	ΝП				1 YES 2 10
25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF								
EXAMINER?	HOSPITAL:	ER/Outpetient 3 🗆 DC		LER:	ne 5 🗆 Rasidence	8 Cheer (9	Panentha)			
27. MANNER OF DEATH	28a. DATE OF		TIME OF	28c. IN.	URY AT	28d. DESCR		NJURY OCC	URED	
Natural 5 Pending 2 Accident Investigation	(Month, De	ny, Year)	INJURY		PRK? YES 2 NO					
	28s. PLACE Of building,	FINJURY — At home, fastc. (Specify)	rm, street,	factory, offic	e	28f. LOCATI City or	ON (Street a Town, State)	and Number	or Rural R	oute Number,
		my knowledge, death oc amination and/or investi								and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIE		4.0			29c. LICENSE NU					(Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WH	-	F OF DEATH (ITEM 27)	Rena Ories		D 36	552		▶ 7.V	NUAL	24 29, 1995
P.TALWAR, 6	121 Mo	NTROSE		AD.	Pock	VILLE	· ^	D.	208	52
31. DATE FILED (ANN. 31 1995	Java da	r's signature								



	1 - STATE REGISTRAR					CEI	RHE	ICAL	E OF	DEA			RE	G. NO.				
	1. DECEDENT'S HAME (First,	, Middle, Las	st)									2. D/	TE OF D				3. TIME OF	DEATH
	Joseph	Co	hen									MC	nth luar		, 19	95	10:4	
rimes.	4. SOCIAL SECURITY NUMB			SEX	8. AGE //	in yrs. last b	oirthday)	IF LINDS	R 1 YEAR	IF UNDER	24 HDC		TE OF BI		,, 13		IPLACE (Stat	
	156-16-3530	77	1.5	₩ 2 □ F			YRS.	MONTHS	DAYS	HOURS	MIN.	(M	onth, Day.	Year)	004	Counti	ry)	
1	9a. FACILITY HAME (If not in:				/	70						~	ot 1	1, 1		<u> </u>	York	
lm								9b. CIT	Y, TOWN	OR LOCATION	ON OF DE	EATH			9c. COU	HTY OF D	EATH	
0	Washington	Adve	ntis	st Hosp	<u>sital</u>			_ Tal	koma	Park					Mon	tgom	ery	
D.	10a, STATE	10b. COU					40- CIT	V TOWN	OR LOCAT									
DIRECTOR	Maryland			George							_						10d. INSIDI LIMITS	E CITY 37
	10e. STREET AHD HUMBER	FII	nce	George	:5		Wes	ot n		svill							1 XYES	2 NO
₹.									1	ZIP CODI							WHAT COUHT	FRY?
Ä	2515 Amhers	st Ro	ad						4	20783	3				USA	7		
FUNERAL	11. MARITAL STATUS	2.0000		WAS DECEDENT FORCES? 1				13.	WAS DEC	ENDEHT C	F HISPAH	IIC ORI	GIN7 (Spe	cify Yes	or Ho-	14. RACE	E — America k, White, atc.	n Indian,
ВУ	1 Never Married 2 1 3 Divoi			IF YES, GIVE W						ecify Cubs	n, mexice Specify		to Ricsn,	atc.)		Speci		
	- Indowed 4 Divol	1000	1														Whi	te
Ë	15. DECI (Specify only	EDEHT'S El	DUCATIO	oleted)		16a. DECE	DEHT'S	USUAL C	OCCUPATIO	OH st of workin	M		16b. KIND	OF BUS	HESS/IN	DUSTRY		
Щ	Elementary/Secondary (0-	-12)	Co	llege (1-4 or 5+	-)	life. D	o NOT us	e retired.))									
M	12					Manag	ger,	Me	at De	epart	ment	: [0	ian	t Fo	od,	Inc.		
COMPLETED	17. FATHER'S HAME (First, Mi	iddle, Last)								18. MOTH	IER'S HA	ME (Fire	st, Middle,	Maiden	Surname)			
BE (Jacob Cohen	1								Eth	nel V	Veis	SS					
	19a. INFORMANT'S HAME (Ty	ype/Print)				19b. I	MAILING	ADDRES	S (Street a	nd Number	or Rural I	Poute N	umber, Cit	y or Town	n, State, Zi	p Code)		
٥	Shirley Kar	ola n	Co	hen						Road,							783	
	20s. METHOD OF DISPOSITE	ION	1		20b.	PLACE AH						_			_	City or To		
	1 (X)Burial 2 Cremation 4 Donation 5 Other		moyt t	from State	ceme M+	etery, crema	tory or of	ther place	emote	7 K X I		1	27				rylan	٦
	21. SIGNATURE OF FUNERAL		LIGHNEE	1	1110	,DC	Danc				RS OF FA						тутап	<u>u</u>
- 1	.01	/		/				E	dwar	d Sag	el F	une	eral	Dir	ecti	.on		
Į.	CHIL	er,	2	w				10	091 1	2002	1110	Di	ko	Roc	kvi1	10.	MD 20	852
	23 PART i Enter the die	111111111	-							V 2120)	TTTC	- 1 4	1170	1100			TID 20	
- 1	LO. FART I. CITED THE UII	seeses, o	r comp	licetions the	ceused	the deet	h. Do n	ot ente	r the mo	de of dyi	ng, suci	h es c	erdiec o	r respi	ratory ar	rest,		oximete
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within—Thours after death. Page 6 may be retained by the hospital or attending physician.

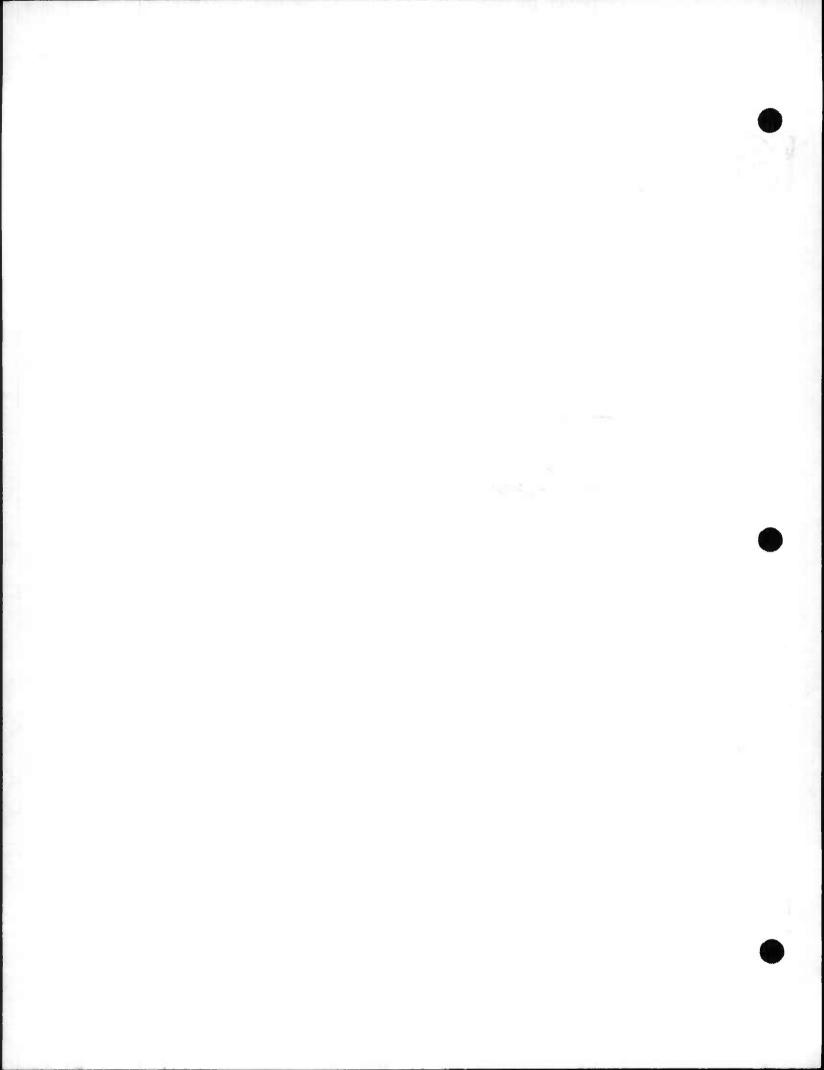
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or remoral.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

32 REGISTRAR'S BIGHATUPS



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

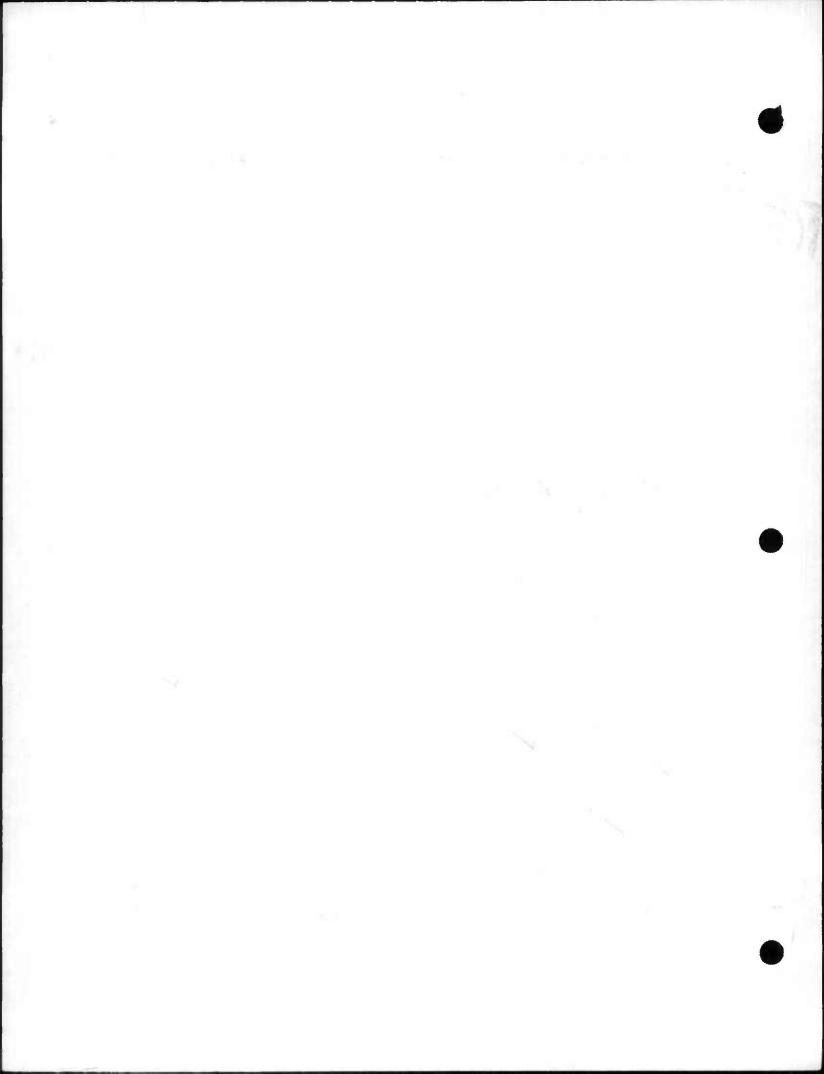
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	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I		IF UNDER 1 YEA		R 24 HRS.	7. DATE OF BIRTH		8. BIRTH	PLACE (State or Foreign	
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AP.	8th Grade	9		Cafet	eria	Work	er	Montg	. Co	unty	Schools	
COMPLETED	17. FATHER'S NAME (First, Middle,	Last)				18. MOT	NER'S NA	NE (First, Middle, Melde				
BE C	Willie	Carpenter	<u>.</u>				Ne	ellie B	urke			
	19e, INFORMANT'S NAME (Type/P)			9b. MAILING	ADDRESS (Stre	et and Numbe	r or Rural R	oute Number, City or To	vn. State. Zi	Code) 2	0.975	
우	Mr Mark Ca						nch Rd,					
	20a. METHOD OF DISPOSITION	-	20b. PLACE	ANDDATEO	FDISPOSITION	(Name of		DATE 20c. L	DCATION	City or Ton	rn State	
	1 Donation 5 Other (Spec		Metr	rematory or oth	er place)	rema	tors	2/2 Al	pyan	dria	Va.	
	21. SIGNATURE OF FUNERAL SER		PICCI	OPOII	22. NAMI	AND ADDRE	SS OF FAC	LITY				
	Snowden Funeral Home. P.A. 20850											
	(-5UK	E/C./M	my	un	2	46 N.	Was	hington	St,	Roc	kville, M	
	23. PART T. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such se cerdiec or respiratory arrest, Approximate											
	snock, or neert isliure. List/only one ceuse on eech line.										Interval Between Onset and Death	
	disease or condition Atrialian tricular disease at the											
	resulting in deeth) a. ATTIONENTRICULAR CISSOCIATION HOURS DUE TO (OR AS A CONSEQUENCE OF):											
,												
<u>ة</u>	DIE TO (OR AS A CONSEQUENCE OF											
CERTIFICATION	cause, Enter UNDERLYING CARAMARY ARTERY DISEASE VENUE											
ᆵ	CAUSE (Disease or Injury that initiated evente		OR AS A CONSE			- 14					1CAICS	
표	resulting in deeth) LAST											
뜅	d											
AL	PART II. Other significent co										WERE AUTOPSY FINDINGS	
DICAL										COMPLETION OF CAUSE		
ME	STATUS PAST ENTREPHIN CARRIAGE RIPACE											
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											
Z	25. WAS CASE REFERRED TO MED	DICAL			(Check only o							
35	EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER:		aldens -	Other (Parriet)		_		
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF		28b. TIME		INJURY AT	sucience (Other (Specify) 28d. DESCRIBE NOW	IN ILIEN OO	CHRED		
<u>-</u>	1 Natural 5 Pendi	(Month, Da		INJU	RY	WORK?	7 NO	200. DESCRIBE NOW	INJUNT OC	CORED		
à	- D Accident	Igation 28e PLACE OF	F IN II IRV A. S	ome to	"	YES 2			111			
	3 Suicide 6 Could 4 Homicide determ	building.	F INJURY — At h etc. (Specify)	ome, rem, st	reet, ractory, o	TIICO		28f. LOCATION (Street City or Town, State	and Number)	or Rural Ro	ute Number,	
ᆲ		G PNYSICIAN: To the best of										
COMPLET		EXAMINER: On the besie of ex									end manner ee stated.	
- 11	29b. SIGNATURE AND TITLE OF C	ERTIFIER A										
8	Thomas		29d, DATE SIGNED (Month, Day, Year)									
2	Thomas Null Discourse Number Discourse State Sta											
	Thomas Militano 7610 CARROll Ave, Takoma PK 20912											
- 1	31. DATE FILED (Month, Day, Year)	995 Julia da	R'S,SIGNATURE	4								

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-train be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760 Tauber 2/10/95 - Cleared with Dr.

DHMH-16 Rev 1/89



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N	11	1	
1215-0020	r attending physicism	use as the burnarin	
BALTIMORE, MARYLAND 21215-002	with yours after death. Page 6 may be retained by the hospital or attending pl	npletely filled in by the funeral director, page 5 should be detached for use as the commation, or removal.	
E, MAR	ay be retained	irector, page 5 should to	
LTIMOR	eath. Page 6 m.	uneral director,	
BA	yours after de	npletely filled in by the funeral c cremation, or removal.	
60.	with	rema	

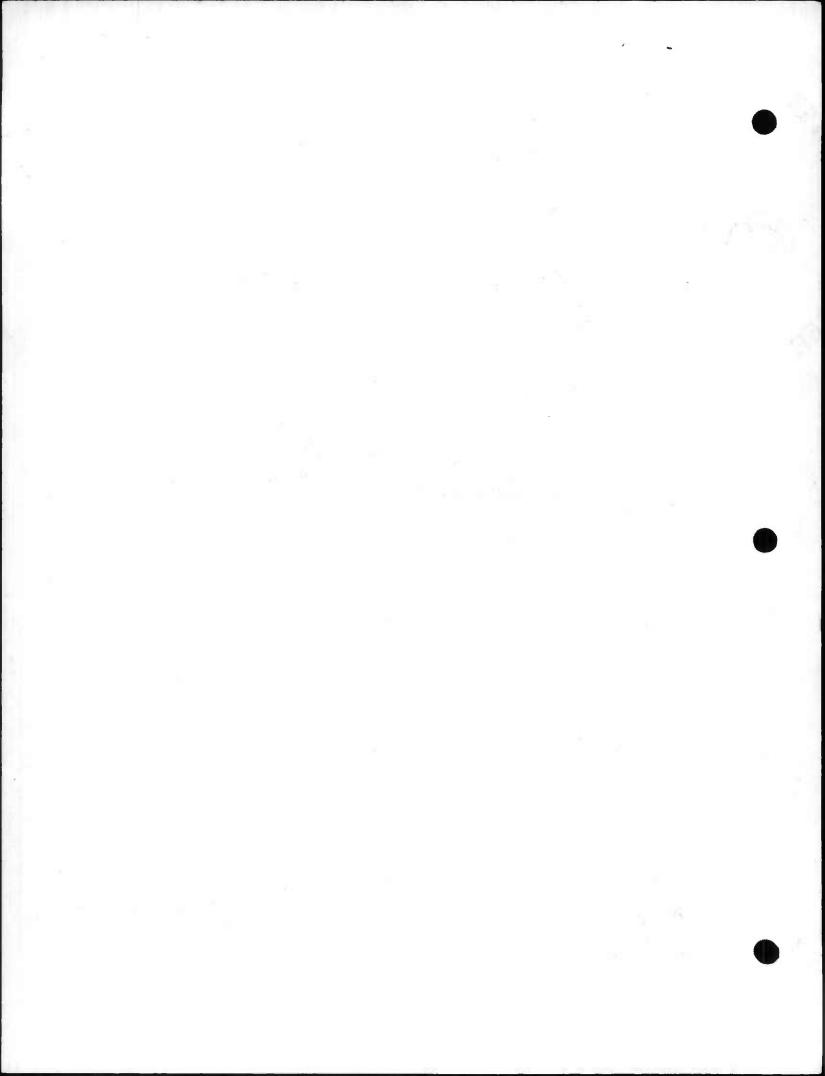
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hoss TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

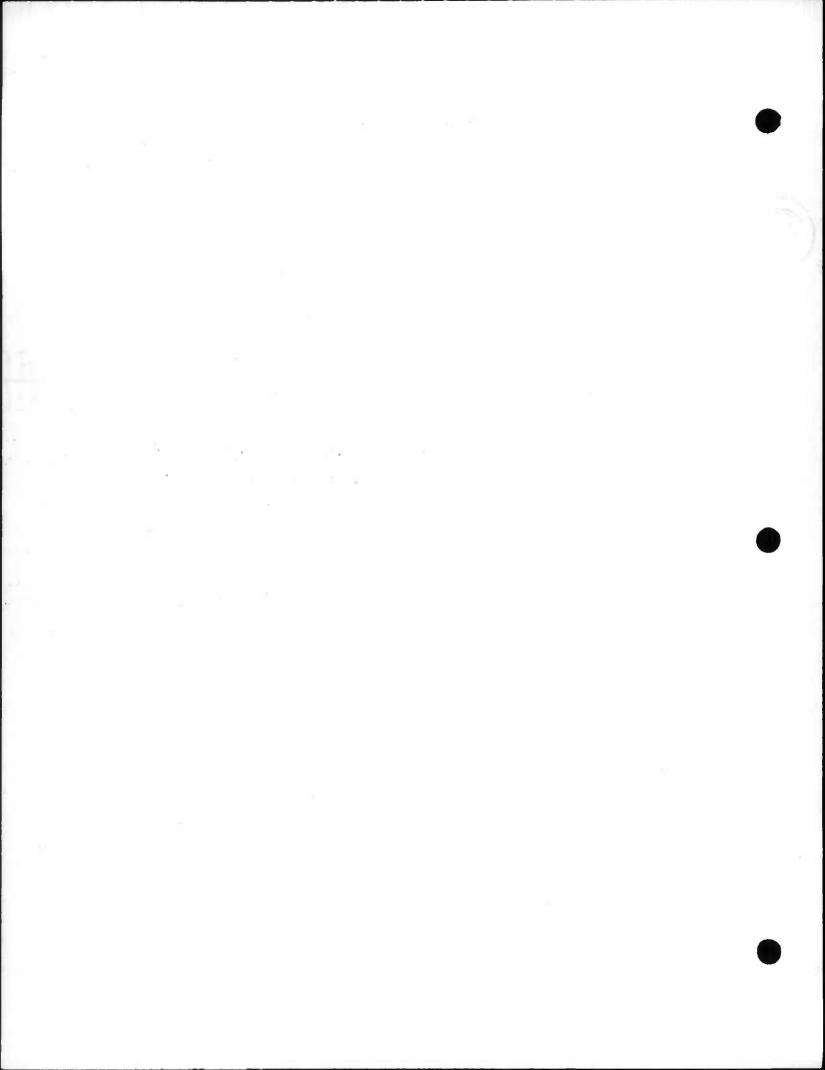
	REGISTRAR		CE	RTIFIC	ATE OF	DEATH	REG. NO.				
i	1. DECEDENT'S NAME (First, Middle, Last)	HAZEL BEN	SON C	orkran			2. DATE OF DEATH MONTH 1/26/95	YEA	3. TIME OF DEATH 12:30 a.4		
- 3	4. SOCIAL SECURITY NUMBER	5. SEX 6	AGE (In yrs. last	birthday) IF	UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BIRTH	I a Bu	DTHRI ACE /State or Familian		
	215-44-6056				YRS. MONTHS DAYS HOURS MIN.			(Month, Day, Year), 1905 MARYLAND			
	9a. FACILITY NAME (If not institution, give s	treet and number)		96	CITY, TOWN	OR LOCATION OF DE		9c. COUNTY O			
DIRECTOR	WILLIAM HILL MANO	R HEALTH	CARE CE	NTER	EASTO	V		TALB	OT		
E I	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY										
		ESTER		HURLOCK				LIMITS?			
FUNERAL	100. STREET AND NUMBER 1518 ACADEMY STRE	ET		101. ZIP CODE 21643			3	10g. CITIZEN C	USA		
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AR				13. WAS DEC	ENDENT OF HISPAN	IC ORIGIN? (Specify Yea	ORIGIN? (Specify Yea or No. 14, RACE — Ameri			
B≼	1 Never Married 2 Married FORCES? 1 YES 2				XINO If yes, specify Cuban, Maxican, Puerto 1 ☐ YES 2 XINO Specify:			Ricen, etc.) Black, White, etc. Specify: WHITE			
	15. DECEOENT'S EDU (Specify only highest grade		16a. DE0	EDENT'S USU	JAL OCCUPATION done during me	ON	16b. KIND OF BUS	b. KIND OF BUSINESS/INDUSTRY			
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5 +)			Do NOT use re	tired.)	or or working		-			
NO.	17. FATHER'S NAME (First, Middle, Last)					18 MOTHER'S NAI	ME (First, Middle, Maiden	Summer			
BE C	WILLIAM DANIEL BE				ALMYR						
D 0	19a. INFORMANT'S NAME (Type/Print)					loute Number, City or Town	n, State, Zip Code				
	MARY LOUISE STEVE			, HURLOCK							
	1\(\text{Densition} \) Burial 2 \(\text{Cremation} \) Cremation 3 \(\text{Rem} \) Rem	oval from Stata	cemetery, crer	nd date of b natory or other WASHII	SPOSITION (N. P. P. P. P. P. P. P. P. P. P. P. P. P.	CEMETERY	1/28 HURI	CATION — CHY O LOCK , M	r Town, Sista D		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY							HOME D	P. O. BOX 207,			
	Jeonous	Lht.	jell	er	106 M	AIN STREE	T, EAST NEV	MARKE'	ZU7, I, MD 21631		
	23. PART I. Exter the diseases, or compilications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate interval Batween										
	IMMEDIATE CAUSE (Finel	01.					(Onset and Death		
	disease or condition resulting in death) Due TO IOR AS A CONSEQUENCE OF):										
	DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	Sequentially list conditions, If eny, laeding to immediate OUE TO (OR AS A CONSEQUENCE OF):										
S	CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF):										
RTE	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST										
		0.									
AL.	PART II. Other significent condition	s contributing to d	eath but not re	sulting in t	he underlyin	g cause given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
8							1 YES 2	1 TES 2 NO	COMPLETION OF CAUSE OF DEATH?		
W							_		1 TES 2 NO		
ä				-							
등	25. WAS CASE REFERRED TO MEDICAL EXAMINER? / LOSSITAL.										
Š.	EXAMINER? 1 YES 2 NO										
PHYSICIAN: MEDICAL	27. MANNER OF DEATH 1 Natural 5 Pending	26s. DATE OF IN (Month, Day,		SATINE DI	W	DRK? YES 2 NO	28d. OEŞCRIBE HOW II	NJURY OCCURED	JURY OCCUREO		
2 Accident investigation 2 Accident investigation 2 Ba PLACE OF INLIBRY — At home farm street factors office.							and Number or Ru	or Rural Route Number,			
ETE	4 Homicide detarmined										
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and manner as stated.										
	296. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER , 29d. DATE SIGNED (Month, Day, Year)										
TO BE	(W) 100+97	Phila	ul V	(),		20	2824.	> 1	26 95		
	ALICA TO	DAN K	OF DEATH (ITEN	J (Type, Pri	M.D. 508 DIEWILD AVE						
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR	S SIGNATURE				1 3,1475	1.1110	101101		
	FFB 0 6 1995	Autia oblavel	un-Rarda	Ц							



FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

į	REGISTRAR		CE	RTIFIC	ATE OF	DEATH	F	REG. NO.									
	1. DECEOENT'S NAME (First, Middle, Last)						2. DATE OF	DATE OF OEATH MONTH DAY YEAR		3. TIME OF DEATH							
		ally blo	WILLOW	Chila	ress		Januar	cy 27 :	1995	7:50	Ам						
- 1	4. SOCIAL SECURITY NUMBER		VGE (In yrs. lasi		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTH 1922	8. BIRTI	IPLACE (State or Fo	reign						
	577-24-4386	1 ☐ M 2 ☐ F	72	YRS.	THE DAYS	HOURS MIN.		ary 25,		ucky							
,	9e. FACILITY NAME (If not institution, give stre	set and number)		96.	CITY, TOWN	OR LOCATION OF D	EATH		COUNTY OF D								
R	616 Greenbrier Dri	Ve			Silwa.	Spring		Ι,									
5	RESIDENCE OF DECEDENT				DIIVE.	Spring			Montgo	mery							
#	10e. STATE 10b. COUNTY			10c. CITY, TO	WN OR LOCA	TION				10d. INSIDE CITY							
0		ntgomery		S	ilver	Spring				1 YES 2	NO						
¥.	10e. STREET AND NUMBER					f. ZIP CODE		10g.	CITIZEN OF	WHAT COUNTRY?							
E	616 Greenbrier Dri	ve				20910		ĺ	J.S.A.								
FUNERAL DIRECTOR	11. MARITAL STATUS	ER IN U.S. ARI		13. WAS DEC	DECENDENT OF HISPANIC ORIG		IN? (Specify Yes or No- 14		6. RACE American Indian								
	1 Leader Westings 5 IV Westings 5 IV Westings 1 1 1 1 1 1 1 1 1							n, atc.)	Spec	k, White, etc.							
BY	3 Widowed 4 Divorced	W	J II			**			Whit								
	15. DECEOENT'S EDUCA (Specify only highest grade of	TION ompleted)	16a. DE0	EDENT'S USU	AL OCCUPATI	ON .	16b. KI	ID OF BUSINESS	111111111111111111111111111111111111111								
91	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT use ret	red.)	ost or working											
P		4	Mat	hemati	cian		Research										
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		187-2			18. MOTHER'S NA	ME (First, Midd	le, Maiden Sumem	ne)								
H	Lawrence Allison	Childress				Annie	Jane F	Petru									
	19a. INFORMANT'S NAME (Type/Print)		19b	MAILING ADD	RESS (Street	and Number or Rural	Route Number, (City or Town, State	Zip Code)								
2	Fav A. Childress					r Drive				1 1 00	010						
	20e. METHOD OF DISPOSITION		20b. PLACEA	ND DATE OF DE	SPOSITION /NO	ame of	DATE	20c. LOCATION	- City or To	VIANA /L	910						
	1 X Buriel 2 Cremation 3 Remov	al from State	St M.	netory or other p	lece)	ry 1/	1										
	21. SIGNATORE OF FUNERAL SERVICE LICE	NSER O	500 11		22. NAME A	ND ADORESS OF FA	CILITY										
1	DI MARIN	1-1-0			Franci	s J. Col	lins F	uneral	Home,	Inc.							
-1	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reepiratory errest, Approximate																
1	23. PART I. Enter the diseases, or co shock, or heart failure. Li	mplications that cau at only one cause of	used the dea on each line.	ith. Do not e	nter the mo	de of dying, suc	h as cerdiec	or reepiratory	errest,	Approxima							
į	IMMEDIATE CAUSE (Final																
	disease or condition resulting in death) a certerio sclerotic text Disease.																
1		DUE TO (OR	AS A CONSEO	UENCE OF):													
z I	Sequentially list conditions (b.																
Ĕ	Sequentially list conditions, if any, leading to immediate OUE TO (OR AS A CONSEQUENCE OF):																
CERTIFICATION	CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF):																
ĖΙ	that initiated events resulting in death) LAST	OUE TO (OR)	AS A CONSEO	UENCE OF):													
買	d.																
	PART ii. Other significant conditions	contributing to deal	th but not re	suiting in th	e underlyin	cause given in	Part i. 24s	. WAS AN AUTOP	SY 24b.	WERE AUTOPSY FII	MOINGS						
2	garkins	0 0	وحصوي				PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE								
	1 Tes 2 No							OF DEATH?									
iii	DID TOPACCO LISE CONTRIBUTE TO CALISE OF DEATH, MESS TO MESS T								1 TYES 2 TN	0							
: MEDICAL	DID TORACCO LICE CONTRI	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN															
AN: ME		BUIE 10 CAUSE		OF BEATH 10				EXAMINER? HOSPITAL: OTHER:									
ICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE	ОТ	HER:												
IYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 \(\text{NO} \) NO	HOSPITAL:	26. PLACE	DOA 4	HER: Nursing Hom	e 5 Anasidence											
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL:	26. PLACE Dutpatient 3 [ОТ	Nursing Hom 28c. INJ WO	URY AT		ecify) BE HOW INJURY	OCCURED								
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 \(\text{NO} \) NO	HOSPITAL: Inpetient 2 ERA 28a. OATE OF INJU (Month, Day, Yel	26. PLACE Dutpatient 3 [RY	DOA 4 DOA 28b. TIME OF INJURY	Nursing Hom 28c. INJ WO M 1 1	URY AT RK? /ES 2 NO			OCCURED								
BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be	HOSPITAL: Inpatient 2 ERA	26. PLACE Dutpetient 3 [RY enr) URY — At hon	DOA 4 DOA 28b. TIME OF INJURY	Nursing Hom 28c. INJ WO M 1 1	URY AT RK? /ES 2 NO	28d. DESCRII			loute Number,							
BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined	HOSPITAL: Inpatient 2 ER/C 28a OATE OF INJU (Month, Day, Yel 28c PLACE OF INJ	26. PLACE Dutpetient 3 [RY enr) URY — At hon	DOA 4 DOA 28b. TIME OF INJURY	Nursing Hom 28c. INJ WO M 1 1	URY AT RK? /ES 2 NO	28d. DESCRII	BE HOW INJURY		loute Number,							
BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIA)	HOSPITAL: Inpatient 2 ER/V 28a. OATE OF INJU (Month, Day, Ve.) 28e. PLACE OF INJ building, stc. (:)	26. PLACE Dutpetlent 3 [RY er) URY — At hom specify)	DOA 4 = 28b. TIME OF INJURY	HER: Nursing Hom 28c. INJ W0 1 1 1	URY AT RK? /ES 2 NO	28d. DESCRIE 28t. LOCATIO City or To	BE HOW INJURY N (Street end Num wn, State)	iber or Rural R								
BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIA)	HOSPITAL: Inpatient 2 ER/C 28a. OATE OF INJU (Month, Day, Vo.) 28e. PLACE OF INJ building, atc. ()	26. PLACE Dutpetlent 3 [RY er) URY — At hom specify)	DOA 4 = 28b. TIME OF INJURY	HER: Nursing Hom 28c. INJ W0 1 1 1	URY AT RK? /ES 2 NO	28d. DESCRIE 28t. LOCATIO City or To	BE HOW INJURY N (Street end Num wn, State)	iber or Rural R		Red.						
COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIA)	HOSPITAL: Inpatient 2 ER/V 28a. OATE OF INJU (Month, Day, Ve.) 28e. PLACE OF INJ building, stc. (:)	26. PLACE Dutpetlent 3 [RY er) URY — At hom specify)	DOA 4 = 28b. TIME OF INJURY	HER: Nursing Hom 28c. INJ W0 1 1 1	URY AT RK? /ES 2 NO	28t. LOCATIO City or 70 to the ceuse(s time, data end	N (Street and Num wn, State) end manner as place, and due to	stated,) and menner se st	rled.						
BE COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	HOSPITAL: Inpatient 2 ER/V 28a. OATE OF INJU (Month, Day, Ve.) 28e. PLACE OF INJ building, stc. (:)	26. PLACE Dutpetlent 3 [RY er) URY — At hom specify)	DOA 4 = 28b. TIME OF INJURY	HER: Nursing Hom 28c. INJ W0 1 1 1	URY AT RK? (ES 2 NO NO NO NO NO NO NO NO NO NO NO NO NO	28d. DESCRII 28t. LOCATIO City or To to the ceuse(s time, data end	N (Street and Num wn, State) end manner as place, and due to	stated,		Med.						
O BE COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	HOSPITAL: Inpatient 2 ER/ 28a. OATE OF INJU (Month, Day, Ye.) 28e. PLACE OF INJ building, atc. (:) AN: To the best of my ki	26. PLACE Dutpatient 3 [RY sr/) URY — At hom Specify) nowledge, desi	DOA 4 28b. TIME OF INJURY ie, tarm, street th occurred at veattgation, in	HER: Nursing Hom 28c. INJ 1 1 1 tectory, office the time, date my opinion, d	URY AT RK? (ES 2 NO NO NO NO NO NO NO NO NO NO NO NO NO	28d. DESCRII 28t. LOCATIO City or To to the ceuse(s time, data end	N (Street and Num wn, State) end manner as place, and due to	stated,) and menner se st	ited.						
O BE COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1. YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICI MEDICAL EXAMINER:	HOSPITAL: Inpatient 2 ER/ 28a. OATE OF INJU (Month, Day, Ye.) 28e. PLACE OF INJ building, atc. (:) AN: To the best of my ki	26. PLACE Dutpatient 3 [RY sr/) URY — At hom Specify) nowledge, desi	DOA 4 28b. TIME OF INJURY 1e, tarm, street th occurred at veatigation, in 27) (Type, Print,	HER: Nursing Hom 28c. INJ W0 1 1 1 tectory, office the time, date my opinion, d	URY AT RK? (ES 2 NO and place, and due eath occured at the 29c. LICENSE NUI	28d. DESCRII 28t. LOCATIO City or To to the ceuse(s time, data end	N (Street end Num. N (Street end Num. N, State)) end manner as place, end due to	stated,) and menner se st	mod.						
TO BE COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICH (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO (County one) 2 MEDICAL EXAMINER: 31. DATE FILED (Month, Day, Year)	HOSPITAL: Inpatient 2 ER/ 28a. OATE OF INJU (Month, Day, Ye.) 28e. PLACE OF INJ building, atc. (:) AN: To the best of my ki	26. PLACE Dutpatient 3 [RY ary ary URY — At hon specify) DEATH (ITEM	DOA 4 29b. TIME OF INJURY 1e, tarm, street th occurred at veatigation, in 27) (Type, Print,	HER: Nursing Hom 28c. INJ 1 1 1 tectory, office the time, date my opinion, d	URY AT RK? (ES 2 NO and place, and due eath occured at the 29c. LICENSE NUI	28d. DESCRIII 28t. LOCATIO City or To to the ceuse(s time, data end	N (Street end Num. N (Street end Num. N, State)) end manner as place, end due to	stated,) and menner se st	nted.						
TO BE COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICI/ONE) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	AN: To the best of my k On the basis of examin COMPLETED CAUSE OF 32. REGISTRAR'S S	26. PLACE Dutpatient 3 [RY ary ary URY — At hon specify) DEATH (ITEM	DOA 4 28b. TIME OF INJURY 10. tarm, street th occurred at veatigation, in 27) (Type, Print,	HER: Nursing Hom 28c. INJ W0 1 1 1 tectory, office the time, date my opinion, d	URY AT RK? (ES 2 NO and place, and due eath occured at the 29c. LICENSE NUI	28d. DESCRIII 28t. LOCATIO City or To to the ceuse(s time, data end	N (Street end Num. N (Street end Num. N, State)) end manner as place, end due to	stated,) and menner se st	nod.						

0



	1 - REGISTRAR			ICATE O		REG. N)				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	DAY	YEAR 3.	. TIME OF DEATH		
		ler Donahu	ie			1 3	1		early Am		
	4. SOCIAL SECURITY NUMBER	1	GE (In yrs. lest birthday)			7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPL Country)	ACE (State or Foreign		
- 1	186-26-3034	1 🛛 M 2 🗆 F 60	YRS.	MONTHS DAYS	HOURS MIN.	Aug/18/1	934		ington DC		
	Se. FACILITY NAME (If not institution, give st	treet and number)		9b. CITY, TOW	CITY, TOWN OR LOCATION OF DEATH			UNTY OF DEAT			
TOP	725 North Rivers:	ide Drive		Crown	sville		Ann	e Arur	ndel		
EC	10a. STATE 10b. COUNTY	r	10c. Cl	TY, TOWN OR LO	CATION			10	Dd. INSIDE CITY		
LOIF	MD Anne	Arundel	Cr	ownsvil					LIMITS?		
FUNERAL DIRECTOR	725 North Rivers:	ide Drive			21032	USA			AT COUNTRY?		
5	11. MARITAL STATUS	12. WAS DECEDENT EVE	R IN U.S. ARMED			NIC ORIGIN? (Specify Y	es or No-	14. RACE —	- American Indian, Vhita, atc.		
BY F	1 Never Married 2 Married FORCES? 1 N YES 2 NO If yes, specify Cuban, Maxica 1 yes 2 No Specify Not available							Specify:			
	3 Widowed 4 Divorced				white						
H	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working						USINESS/IN	IDUSTRY			
	Elementary/Secondary (0-12)										
MP		ent									
COMPLETED	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname)										
BE (
0	19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
Ĕ	Barbara A. Donahue 725 North Riverside Drive/Crownsville/MD										
	20a. METHOD OF DISPOSITION 1										
	4 Donation s Other (Specify) Metropolitan Crematory 2/1 Alexandria VA										
	21. SIGNATURE OF FUNERAL SERVICE LIC										
Melanie Wilhelm Wagone Annapolis MD 21401											
	23. PART i. Enter the diseases, or o						piratory s	rrest.	Approximata		
	shock, or heart failure.	List only one cause of	n each iina.		, , ,				Interval Batween		
	IMMEDIATE CAUSE (Final disease or condition	The R	o correct	1514 (1	cro. t				Onset and Death		
	resulting in death)	a. DUE TO (OR A	S A CONSEQUENCE	OFI:							
,		b. Lcuken	ic Cula	ver on.	infiltate	Tool 1	2001		j		
0	Sequentially list conditions, if any, leading to immediate	DUE TO (OR A	S A CONSEQUENCE	OF):	77 11 (1170	and	11 0000	000			
A	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events OUE TO (OR AS A CONSEQUENCE OF):										
필											
F	resulting in death) LAST										
100	resolding in death) CAST	4									
CERTIFICATION		d									
	PART II. Other significant condition	d.	h but not resulting	in the undarly	ing cause given In	Part i. 24a, WAS A	N AUTOPSY	A	ERE AUTOPSY FINDINGS MILABLE PRIOR TO		
DICAL		d.	h but not resulting	in the undarly	ing cause given in	Part i. 24a, WAS A PERF	PRMED?	AA Ci			
DICAL	PART II. Other significant condition	d.	h but not resulting	in the undarly	ing cause given in	PERF	PRMED?	AA CI OI	MILABLE PRIOR TO OMPLETION OF CAUSE		
DICAL	PART II. Other significant condition main ut	d.	h but not resulting	in the undarly	ing cause given in	PERF	PRMED?	AA CI OI	MILABLE PRIOR TO OMPLETION DF CAUSE F DEATH?		
DICAL	PART II. Other significant condition Malnut 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	d. a contributing to deat rifio	h but not resulting	28.	ing cause given in	PERF	PRMED?	AA CI OI	MILABLE PRIOR TO OMPLETION DF CAUSE F DEATH?		
DICAL	PART II. Other significant condition Malnut 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 2010	d.		28.		PERF(1 YES	PRMED?	AA CI OI	MILABLE PRIOR TO OMPLETION DF CAUSE F DEATH?		
DICAL	PART II. Other significant condition Male Land Land Land Land Land Land Land Land	a contributing to deat	Dutpetlent 3 DOA	28. OTHER: 4 Nursing H	PLACE OF OEATH (Ch	PERF(1 YES	PRMED?	AN CI	MILABLE PRIOR TO OMPLETION DF CAUSE F DEATH?		
PHYSICIAN: MEDICAL	PART II. Other significant condition Malnut 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 2010	d. a contributing to deat T T 0 V HOSPITAL: 1 Inpetient 2 ER/C	Dutpetlent 3 DOA	28. OTHER: 4 — Nursing H ME OF 28c. I	PLACE OF OEATH (Choome 5) (Chaeldence	PERF(1 YES seck only one) 8 Other (Specify)	PRMED?	AN CI	MILABLE PRIOR TO OMPLETION DF CAUSE F DEATH?		
BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Pletural 5 Pending Investigation 3 Suicids 6 Could not be	HOSPITAL: 1 Inpetient 2 = ER/C 28a. OATE OF INJUI	Dutpatient 3 DOA RY 28b. Til IN URY — At home, term,	OTHER: 4 Nursing H ME OF 28c.	PLACE OF GEATH (Choome D) PRESIDENCE INJURY AT WORK? YES 2 NO	PERF 1 YES 1 YES Other (Specify) 28d. OE\$CRIBE HOW 28f. LOCATION (Street	PRMED? 2X NO INJURY OF	M CC CCURED	MILABLE PRIOR TO OMPLETION DF CAUSE FORTH?		
BY PHYSICIAN: MEDICAL	PART II. Other significant condition Ma (n u f 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF OEATH 1 Shetural 5 Pending Investigation	HOSPITAL: 1 Inpatient 2 ERV. 28a. PLACE OF INJUI 28a. PLACE OF INJUI	Dutpatient 3 DOA RY 28b. Til IN URY — At home, term,	OTHER: 4 Nursing H ME OF 28c.	PLACE OF GEATH (Choome D) PRESIDENCE INJURY AT WORK? YES 2 NO	PERF- 1 YES seck only one) 8 Other (Specify) 28d. DESCRIBE HOW	PRMED? 2X NO INJURY OF	M CC CCURED	MILABLE PRIOR TO OMPLETION DF CAUSE FORTH?		
BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 WIO 27. MANNER OF OEATH 1 Shatural 5 Pending Investigation 3 Suicids 6 Could not be datarminad 29a. CERTIFIER	HOSPITAL: 1 Inpatient 2 ERV. 28a. PLACE OF INJUI 28a. PLACE OF INJUI	Dutpatient 3 DOA RY 28b. Til in URY — At home, tarm, Specify)	OTHER: 4 Nursing H ME OF JURY M 1 [street, factory, of	PLACE OF OEATH (Ch ome 5 Residence INJURY AT WORK? YES 2 NO	PERF. 1 YES 1 YES Other (Specify) 28d. OE\$CRIBE HOW 28f. LOCATION (Street City or Town, State	PRIMED? 2X NO INJURY Of and Numbers	CCURED CCURED Or Flurel Rou	MILABLE PRIOR TO OMPLETION DF CAUSE FORTH?		
BY PHYSICIAN: MEDICAL	PART II. Other significant condition TO IN UT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Pending	HOSPITAL: 1 Inpatient 2 ER/C 28a. PLACE OF INJUI building, etc. (3)	Dutpatient 3 DOA RY 28b. Til in URY — At home, term, Specify)	OTHER: 4 Nursing H ME OF 28c. I JURY M 1 [street, factory, of	PLACE OF OEATH (Chome 5) Residence INJURY AT WORK? YES 2 NO	PERF. 1 YES 1 YES 5 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State) to the cause(s) and m	PRIMED? 2X NO INJURY Of and Numbers)	CCURED or or Rural Rou	MILABLE PRIOR TO OMPLETION DF CAUSE F OEATH? YES 2 NO		
COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other significant condition TO IN UT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Pending	HOSPITAL: 1 Inpetient 2 ER/C 28a. OATE OF INJUI (Month, Day, Yea 28a. PLACE OF INJUI building, etc. (3)	Dutpatient 3 DOA RY 28b, Til IN URY — At home, tarm, Specify) nowledge, death occur ation and/or investigati	28. 1 OTHER: 4 Nursing H ME OF JURY M 1 [street, tactory, of	PLACE OF OEATH (Chome By Residence INJURY AT WORK? YES 2 NO Iffice It was and place, and due to, death occurred at the	PERF- 1 YES The control of the course of th	PAMED? 2X NO INJURY Of tand Numbers)	CCURED or or Rural Rou ated.	MILABLE PRIOR TO OMPLETION DF CAUSE FORTH? YES 2 NO te Number,		
BE COMPLETED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	HOSPITAL: 1 Inpatient 2 ER/C 28a. OATE OF INJUI (Month, Day, Yea 28a. PLACE OF INJUI building, etc. (3)	Dutpatient 3 DOA RY 28b, Til IN URY — At home, tarm, Specify) nowledge, death occur ation and/or investigati	OTHER: 4 Nursing H ME OF 28c. I JURY M 1 [street, factory, of	PLACE OF OEATH (Chome By Residence INJURY AT WORK? YES 2 NO Iffice It was and place, and due to, death occurred at the	PERF- 1 YES The control of the course of th	PAMED? 2X NO INJURY Of tand Numbers)	CCURED or or Rural Rou ated.	MILABLE PRIOR TO OMPLETION DF CAUSE F OEATH? YES 2 NO		
COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other significant condition TO DESCRIPTION 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Detural 5 Pending Investigation 3 Suicide 6 Could not be datarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER	HOSPITAL: 1 Inpetient 2 ERVC 28a. OATE OF INJUI (Month, Day, Yes 28a. PLACE OF INJUI building, etc. (3)	Dutpatient 3 DOA RY 28b, Til IN URY — At home, tarm, Specify) J. SERLE	28. 1 OTHER: 4 Nursing H ME OF JURY M 1 street, tactory, of the time, doon, in my opinion MITSOS N	PLACE OF OEATH (Chome By Residence INJURY AT WORK? YES 2 NO Iffice It was and place, and due to, death occurred at the	PERF- 1 YES The control of the course of th	PAMED? 2X NO INJURY Of tand Numbers)	CCURED or or Rural Rou ated.	MILABLE PRIOR TO OMPLETION DF CAUSE FORTH? YES 2 NO te Number,		
BE COMPLETED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Accidant Investigation Suicida Gould not be distarmined Check only one) 2 MEDICAL EXAMINE MED	HOSPITAL: 1 Inpetient 2 ER/C 28a. DATE OF INJU (Month, Day, Yer 28a. PLACE OF INJ building, etc. (S	Dutpatient 3 DOA RY 28b, Til IN URY — At home, tarm, Specify) J. SERLE	28. 1 OTHER: 4 Nursing H ME OF JURY M 1 street, tactory, of the time, doon, in my opinion MITSOS N	PLACE OF OEATH (Chome By Residence INJURY AT WORK? YES 2 NO Iffice It was and place, and due to, death occurred at the	PERF- 1 YES The control of the course of th	PRIMED? 2X NO INJURY Of and Number as stand due to 129d, DA	CCURED or or Rural Rou ated.	MILABLE PRIOR TO DOMPLETION OF CAUSE FOATH? YES 2 NO to Number, and menner as stated.		

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a flours after death. Page 6 may be retained by the law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunkal-transit be filed within 72 hours after death with the State Gept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DHMH-18 Rev 1/89

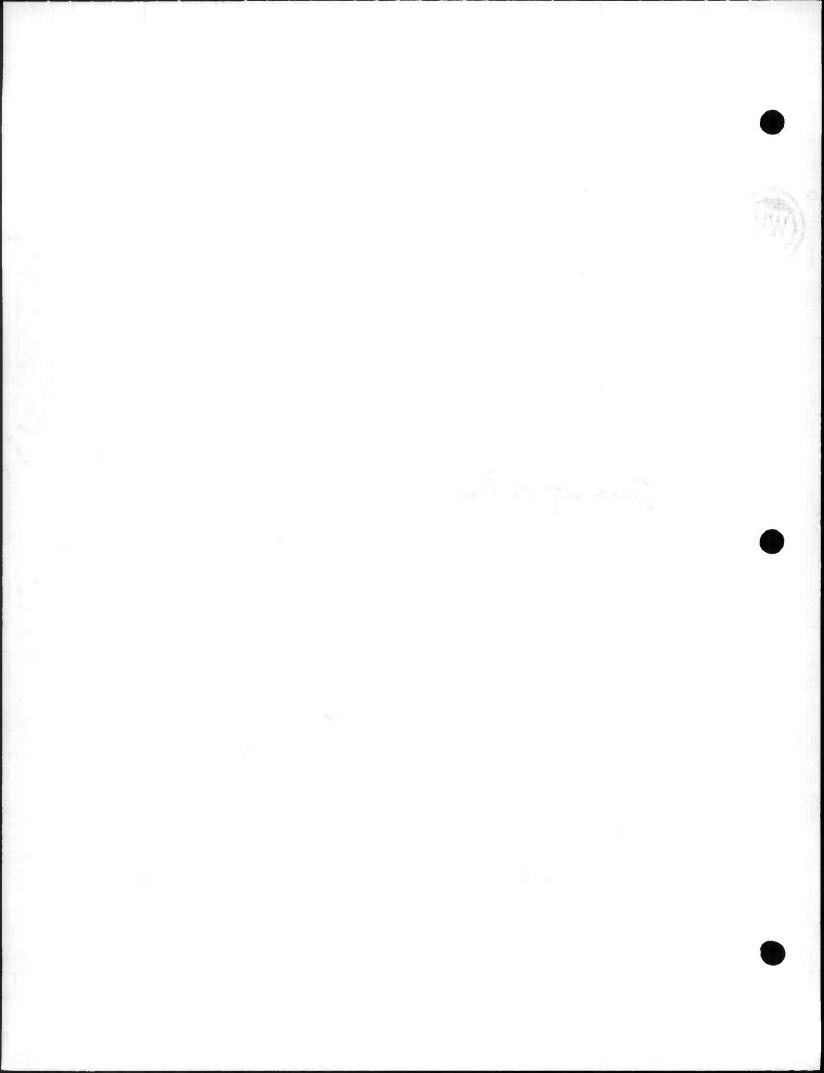
	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.												
N.	1. DECEDENT'S NAME (First, Middle, Last)				- CATT		DEA		2. D	ATE OF DEATH			3. TIME OF DEATH
	Max			Deu	tchm	an			Feb	oruary 1		5	9:25 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER		IF UNDER		7. 0/	TE DE BIRTH		8. BIRTH	HPLACE (State or Foreign
1	116-07-5166	1X M 2 🗆 F	88	YRS.	MONTHS	DAYS	HOURS	MIN.	Ap	onth, Day, Year)	906		Russia
	9e. FACILITY NAME (If not institution, give st										INTY OF D		
OR	1766 Dunton Road				Α	nnap	olis				An	ne A	rundel
ECI	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY			10c. CITY, TOWN DR LOCATION				194					
DIRECTOR	MD Anne	Arundel				nnap			1				10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER						ZIP CDDI	E .	10g. CITIZEN OF WHAT				
FUNERAL	1766 Dunton Road						2	1401					States
O.	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. ARI	MED	13.	WAS DEC	ENDENT D	F HISPAN	NIC OR	GIN? (Specify Yea		14, RACI	E — American Indian.
ВУ Е	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE W	YES 2 N	10			2 ND			rto Rican, etc.)		Spec	k, White, etc.
												"" White	
IE	1S. DECEDENT'S EDUC (Specify only highest grade	(Gi	CEDENT'S ve kind of a Do NOT us	Work done	CCUPATIO	N st of workin	ng		16b. KIND OF BUS	INESS/IN	DUSTRY		
PLE	Elementary/Secondary (0-12)	College (1-4 or 5 d)							New York	k Sta	ate (Government
COMPLETED	12 Auditor New York State Go 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Surname)									307011110111			
ш	Joseph Deutchman Freida Schectman												
TO B	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
۴	Rochelle Zap 1757 Dunton Road Annapolis, Maryland 21401												
	20a. METHOD DF DISPOSITION 1 DATE 20b. PLACE AND DATE DISPOSITION (Name of cametery, cremetory of other place) 20b. PLACE AND DATE DISPOSITION (Name of cametery, cremetory of other place) Beth David Cemetery 2/3/95 Elmont. New York												
	4 Donation 5 Other (Specify)		Beth	David	l Cen	eter	У	2/3/	/95	EIm	ont,	New	/ York
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE	1		22.	NAME AN	D ADDRES	SS OF FA	CILITY	John M.	Tayl	or F	uneral Home
	Jame of	Phill	so		14	7 Du	ike o	f GI	loud	cester S	t. A	nnap	olis, MD
	23. PART i. Enter the diseasee, or contained ahock, or haert failure. I	omplications that	caused the dec	eth. Do r	ot anter	tha mo	de of dyl	ng, auc	h as c	ardiec or reepl	ratory ari	raet,	Approximate
	IMMEDIATE CAUSE (Final									0			intarval Between Onset and Death
	disease or condition resulting in deeth)		ONGEST	IVE		EA	21	FA	146	IKE			WEEK
	DUE TO (OR AS A CONSEQUENCE OF):												
O	Sequentielly list conditions, b	DUE TO	OR AS A CONSEO	LIENCE DI	n.			_					
AT	cause. Enter UNDERLYING												
Ĕ	CAUSE (Diseese or injury thet initieted events	DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	resulting in deeth) LAST	l											
07	PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS												
ICAL										PERFOR	MED?	1	AVAILABLE PRIOR TO COMPLETION DF CAUSE
E						-				1 🗆 YES 🗶	ND ND		DF DEATH?
2	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEAT	TH YE	SIL	NO D	UNC	FRTAIN	νП				1 TES 2 ND
M	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE						<u> </u>				
SIC	_ \	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER		5 🗆 Rei	aldenca	8 Vo	ther (Specify)	ROUP	Hom	E
PHYSICIAN: MEDI	27. MANNER OF DEATH	28a. DATE DF (Month, De	INJURY IV, Year)	28b. TIM	E DF URY	26c. INJU			-	DESCRIBE HOW IN	JURY OC		
BY	1 Natural 5 Pending 2 Accident Investigation		/ · · · · · · · · · · · · · · · · · · ·		М		ES 2	NO					
	3 Suicide 6 Could not be 4 Homicide datarmined	26a, PLACE Of building,	F INJURY — At hon stc. (Specify)	ne, farm, a	treet, tect	ory, office			26t. L.	OCATION (Street a	nd Number	or Rural P	Poute Number,
COMPLETED	29a. CERTIFIER (Check only one)												
S	2 MEDICAL EXAMINER	t: On the basis of ex	amination and/or in	rvestigatio	n, In my o	pinion, de	eth occur	ed at the	time, d	ata and place, and	due to th	e cause(a) end manner ee stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	- XA- S					29c. LICE						(Month, Day, Year)
2	30 NAME AND ADDRESS OF STREET	So The	w, MU				D3	0701			₽Fe	brua	ry 1, 1995
-	30. NAME AND ADDRESS OF PERSON WHO R. Scott Eden, M					nnan	olic	NA) 21	1401 (41	0.22	4.00	70)
	31. DATE FILED (Month, Day, Year)					·map	0113	, 17		701 (41	0-22		10)
	FEB 02 1995 32. REGISTBAR'S SIGNATURE ROUGHS												

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-train be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100 miles

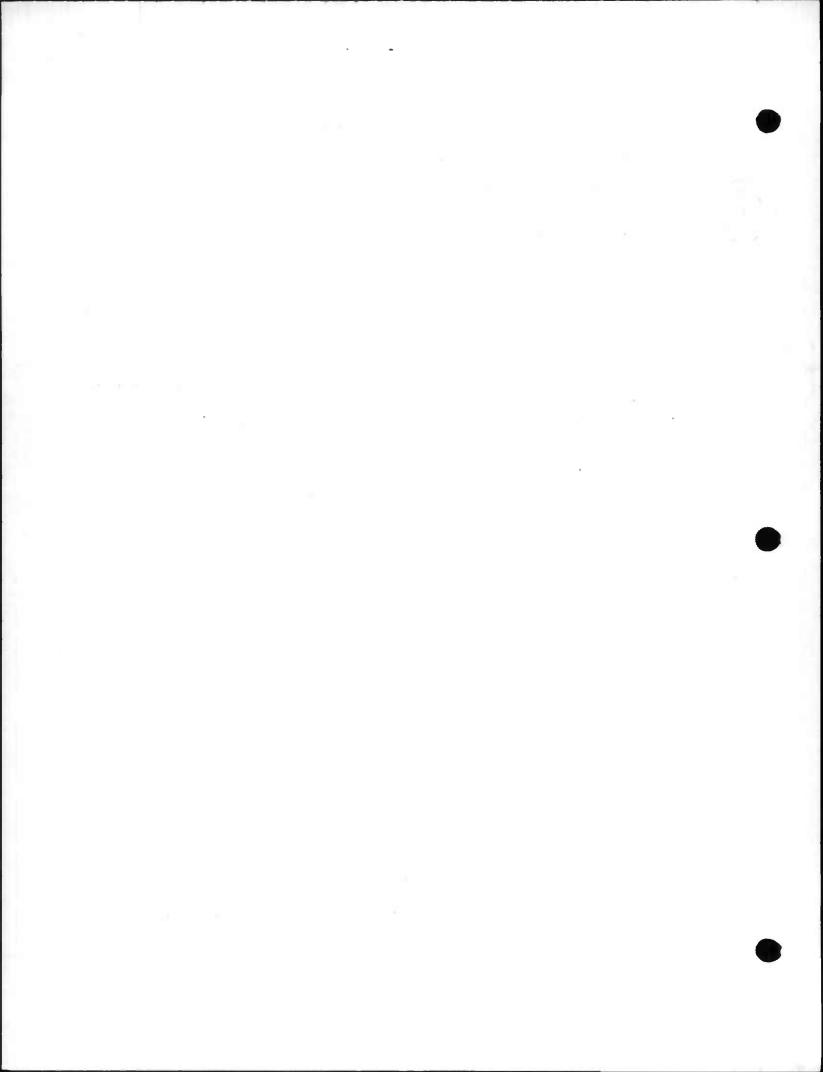
DHMH-18 Rev 1/89



IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

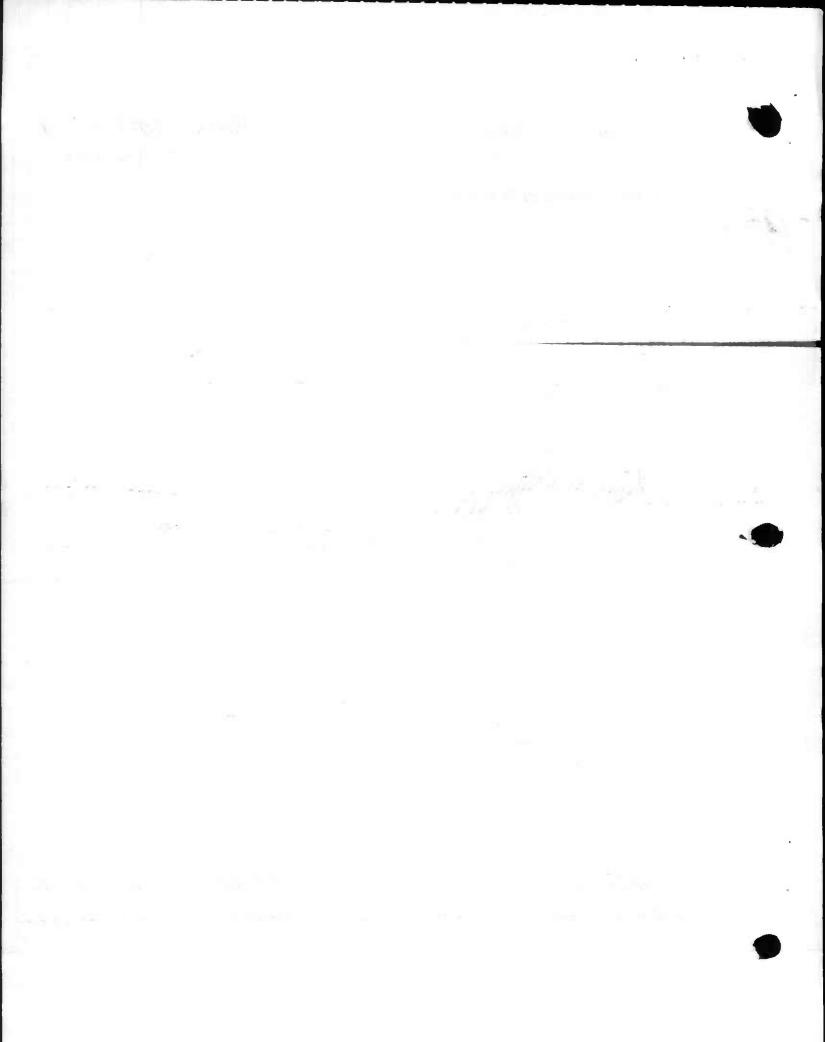
FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR CERTIFICATE OF DEATH REG. NO.									
- 8	1. DECEDENT'S HAME (First, Middle, Last)				2. DATE OF DEA	ATH DAY	YEAR	3. TIME OF DEATH		
- 1	Nancy Lee		DeMari	•	Januar		995	11:49A M		
	4. SOCIAL SECURITY HUMBER 5. SEX 6. AGE (I	in yrs. last birthday)	IF UNDER 1 YEAR							
		4 YRS.	MONTHS DAYS	HOURS MIN.	Month, Day, N	, 1930	Mar	yland		
NG.	3824 Tarrington Place			Plains	ATH	9c. 000	rles	AIII		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY									
			TOWN OR LOCAT			10d.				
	Maryland Charles		Vhite I				1 ☐ YES 2 📉 HO			
FUNERAL	3824 Terrington Place		101	20695	U.S.A.			HAT COUNTRY?		
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	EHDENT OF HISPAH	IC ORIGIN? (Spec	Ify Yea or No-	14. RACE -	- American Indian, White, etc.		
ВУ	1 Hever Married 2 Married FORCES? 1 YES IF YES, GIVE WAR OR DA			2 N HO Specify		IC.)	Specify: Whi			
	15. DECEDENT'S EDUCATIOH (Specify only highest grade completed)	18e. DECEDENT'S L	JSUAL OCCUPATION	ON .	16b. KIND C	OF BUSINESS/INC				
E	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT use	*							
COMPLETED	9 17. FATNER'S HAME (First, Middle, Last)	Hon	nemakeı			Home				
BE CC	Lawrence E. Dixon			Mildred			Pete	rs		
TO B	19a. INFORMAHT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Street a	nd Number or Rural R	Noute Number, City	or Town, State, Zip	Code)			
ř	Donald DeMarr	3824	Terrir	gton Pl	L. Whit	te Pla	ins,	MD 20695		
	20a. METNOD QF, DISPOSITION 20b. PLACE AND DATE OF DISPOSITION IN DATE 20c. LOCATION — City of Town.									
	Metropolitan Crematory 2/2 Alexandria, VA									
21. SIGNATURE OF FUHERAL SERVICE LICENSEE M00817 Arehart-Echols Funeral Home,										
	Bauten C. Echor II	I	P.O.	Box 567	7 LaPla	ata, M	D 20	646		
	23. PART I. Enter the diseasea, or complications that caused abook, or heart failure. List only one cause on as	the deeth. Do no	ot sntsr ths mo	de of dying, auch	s cardiac or	respiratory arr	rsst,	Approximata interval Between		
	IMMEDIATE CAUSE (Final							Onset and Dsath		
	disease or condition s. CARCIN	AMOV	OF	HEAD	7 A	NEC	K	lyn		
	DUE TO (OR AS A	CONSEQUENCE OF	EOUENCE OF):							
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	CONSEQUENCE OF):					-		
S	csuse, Enter UNDERLYING CAUSE (Disease or Injury							-		
E	that initiated events resulting in death) LAST	CONSEQUENCE OF):							
H	d									
	PART II. Other significant conditions contributing to death but	ut not resulting in	the underlying	csuse givan in i	Part I. 24a. W	AS AN AUTOPSY	24b. V	VERE AUTOPSY FINDINGS		
DICAL					PE	ERFORMED?	A	WAILABLE PRIOR TO COMPLETION OF CAUSE		
					— ¹□ º	ES 2 NO	٥	OF DEATH?		
∑	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	E DEATH VE	I NO E	LINICEDTAIN			1	I TYES 2 NO		
N N	25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEATH		ONCERIAIN	<u> </u>					
PHYSICIAN: ME	EXAMINER?		OTHER:	5 Residence	8 Other (Specifi					
Ě	27. MAHHER OF DEATH 28s. DATE OF IHJURY	28b. TIME	OF 28c. INJ	URY AT		NOW INJURY OC	CURED			
	Hatural 5 Pending (Month, Day, Year)	INJU	M 1 U	RK? 'ES 2 NO						
2 Accident 3 Suicide 4 Homicide 5 Could not be datermined 29a. CERTIFUNG PNYSICIAN: To the beat of my knowledge, death occurred at the lime, date and place, and due to the cause(e) and menner as attated. M 1 YES 2 NO 28f. LOCATION (Street and Number or Rural Route Number of Rural Rou										
									2 1	29a. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the beat of my knowledge)
8	one) 2 MEDICAL EXAMINER: On the basis of examination							and menner as stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIER	0		29c. LICENSE NUM	BER	29d. DAT	E SIGNED (A	Month, Day, Year)		
BE	Koush M. M.	20 hu		D-2835	2	▶ 2	1-1-	95		
유	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEA	TN (ITEM 27) (Type,	Print)			2				
	Krishan Mathur, MD 11340	Pembro	oke Sq	uare Wa	ldorf.) Marvla	and 2	20603		
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNA	TURE					-114 6			
	FEB 0 3 1995 Julia Davids	or Kardall								
								DNMH-16 Ray 1/89		



,	4								95	04630	ļ
	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR					NTAL HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last) Agnes							DATE OF DEATH	AY	3. TIME OF DEA	тн
	VIRGINIA DA	WSON					F	EBRUARY	7/9	95 ////	4 M
	4.000	SEX 6. AGE	(In yrs. last birthday) YRS.	MONTHS	DAYS	HOURS M		DATE OF BIRTH (Month, Day, Year) DV. 13, 1	ا ۱۵	8. BIRTHPLACE (State or F	oreign
	9a. FACILITY NAME (If not institution, give street) '110.	9b. CITY.	TOWN O	R LOCATION (Maryland NTY OF DEATH	
Œ			-		ALTIMORE CITY						
DIRECTOR	UNION MEMORIAI	- HOSPITA									
IRE	100. STATE 106. COUNTY Maryland Baltin	mara			R LOCATION E Hall					10d. INSIDE CIT LIMITS? 1 TYES 2 X	
L D	Maryland Baltin	шоте		ATIT CE	_	ZIP CODE			10g. CITI	IZEN OF WHAT COUNTRY?	NO
FUNERAL	20500 Kirkwood	d Shop Ro	ad			21161			U.	S.A.	
ON		. WAS DECEDENT EVER		13. V	NAS DEC	ENDENT OF H	IISPANIC C	ORIGIN? (Specify Ye		14. RACE — American Ind Bleck, White, atc.	llan,
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	DATES	1	YES	2 NO S	Specify:	varto Hican, atc.)		Specify:	_	
DB	15. DECEDENT'S EDUCATI	S USUAL OC	CLIPATIO	NA.		16b. KIND OF BU	SINESS/IND	Whit	.e		
TED	(Specify only highest grade con	npleted)	(Give kind of life. Do NOT u	work done a	during mo	st of working		1001 11110 07 00	01112001112		
COMP	TT		House	wife				Own	Home	!	
17. FATHER'S NAME (First, Middle, Last) Ferdinand Folks 18. MOTHER'S NAME (First, Middle, Malden Surname) Mamie Smith											
The INCOMENTS HAME TO DOWN											
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry J. West 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5121 West Rd., White Hall, MD 21161											
20e. METHOD OF DISPOSITION 1 M Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION [Name of the control of the contr											
	4 Donation 5 Other (Specify)	from State	est Libe	erty (Ceme	tery ^r	199	$\frac{1}{5}$, Wh		Hall, MD	
	21. SIGNATURE OF FUNERAL SERVICE LICENS			22.1	NAME AN	D ADDRESS	OF FACILIT	TY		_	
	Daren W.	lessolut		24	4 Se	econd	St.	. New F	tuar reed	y, Inc. om, PA 17	349
	23. PART I. Ental the disesses, or com shock, or heart failure. List	pications that cause	d the death. Do	not enter	tha mo	da of dying,	, auch as	cardiac or rasp	iratory an	reat, Approxim	nata
	IMMEDIATE CAUSE (Final										
	disease or condition a. EXSANQUINATION								140	rice	
_	reaulting in death) a. LX3AVQUINATION DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, b. PUPTURE OF THORACIC ACRTA Unknown										
ERTIFICATION											yu
CA	ff any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury										
THE	that initiated eventa resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE O	F):							
CER	d								_		
	PART II. Other significant conditions co	ontributing to death b	but not reaulting	in the und	deriying	csuse giva	n in Pari	t I. 24s. WAS AN		24b. WERE AUTOPSY F	
MEDICAL								PERFOR		AMILABLE PRIOR COMPLETION OF OF DEATH?	
									Till	1 - YES 2 12	NO
ä	DID TOBACCO USE CONTRIB	UTE TO CAUSE C				UNCER	TAIN [
PHYSICIAN:		OSPITAL:	28. PLACE OF DEA	OTHER	1:						
H X	27. MANNER OF DEATH	Inpatient 2 ER/Out	patient 3 DOA 28b. TIN		Ing Home 28c. INJU		_	Other (Specify) J. DESCRIBE HOW I	N III III OOO	Ounen.	
ВУ Р	1 Natural 5 Pending	(Month, Day, Year)	IN.	JURY M	WOF	RK?		S. DESCRIBE NOW I	NJUNT OCC	UNED	
2 Culable — 28e PLACE OF IN HIRV — At home form street feature, attle-								LOCATION (Street	and Number	or Rural Route Number,	-
	4 Homicide determined City or Town, State)										
COMPLETED	290. CERTIFIER 1 CERTIFYING PHYSICIAN										
δ N	one) 2 MEDICAL EXAMINER: O	n the beels of exeminatio	n end/or investigation	on, In my op	olnion, de	with occured a	it the time,	, data and place, an	d dua to the	a cause(a) and manner as s	stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE	E NUMBER	- 17	29d. DATE	SIGNED (Month, Day, Year)	
2	1. Mane	MA			0458 90			90	► FEBRUARY-7-95		

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day. 5 1995 FEB



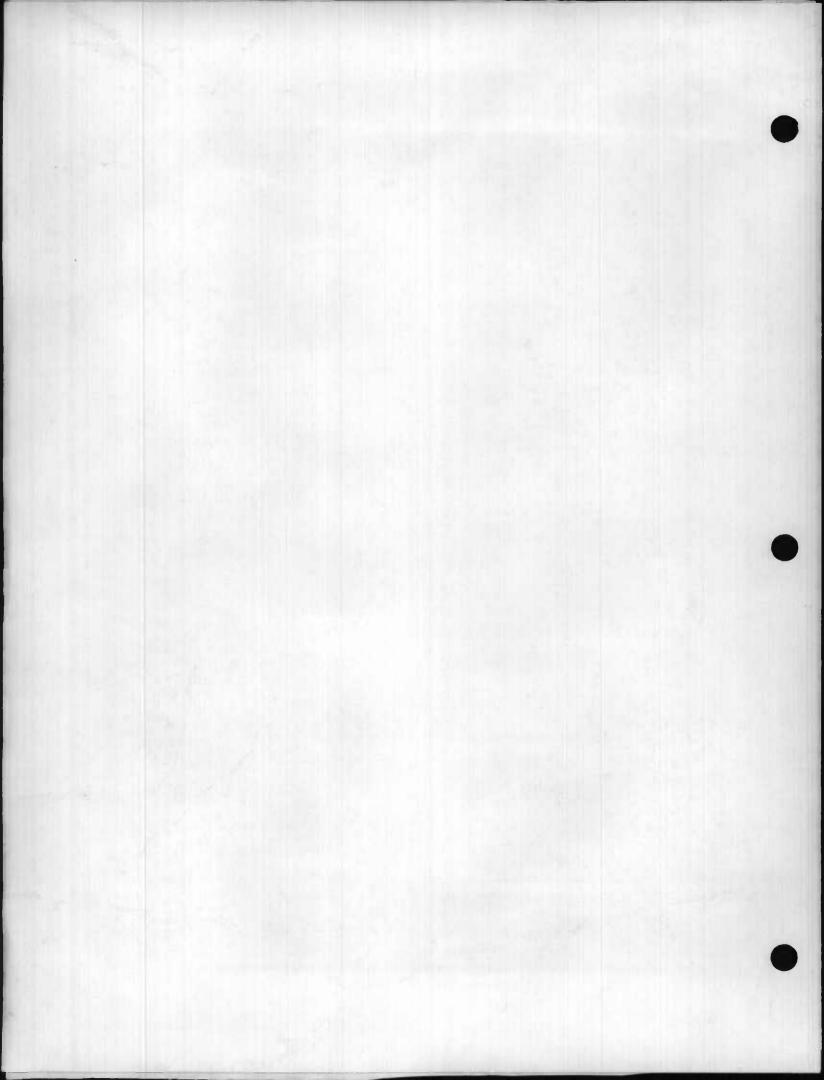
95 04630

	ITEMS:	23c,25,27,29d,	PER	DR.	FILM	6-735	5/13/96	t.t
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	AGUCS	DAWSON						2. DATE OF DEATH			TIME OF E
	215-09-2755	3. 68 X 8.	AGE (lis year face)	YAS.	# UNDER 1	PEAR	F UNUER 24 IRES	Nov. 13	1914	Caunty	
	Do TACILLY NAME IF not be a dim give				PD CITY	TOWN C	DA LOCATION OF D	-	the same of the sa	PICLE	yland
CTOR	UNION MEMORI	AL HOSPIT	AL	mana de ma de dels e	BAL	TI	MORE CI	TY			ייישיקאש א עלי"נ
0.	100 GTATE TOU COUN		And the second second second second		Y, TOWN OR				OJ. INSIDE		
10	Maryland Bal	imore		1 ,	hite		SIE CODE		100 0111	ZEN OF W	HAI COUNTR
FUNERAL	20500 Kirkwo	od Shop I	Road					U.S.			
EY FUR	11 MARITAL STATUS 1 [Nover Married 2 [] Married 3 [] Widowed 4 [] Diverted	12. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Vas or No.) 14. YES 2 YE								14 MACE Bock	- A garteni
ED	15. DECEOTED S & ED (Specify may plyingly at	UGATION (i campleted)	180. DE	CEDENT'S	USUAL OCC	SUPATIO	on et of working	16u. KIND	OF BUSINE SAND	of the	
THE HE	11			USCW				Ow	n Bome		
00	17 FATDER'S NAME (First Models, Last)						TE MOTHERS NA	ME (1 = a - Administration in		78	
8	Ferdinand Fo	LKS						Smith		30	200
12		Terry . West 5121 West Rd., White Fill									161
	Par METHOD OF DISPOSITION IN Burla 2 Fee within 3 Fee	oval from Slate	200 PLACE	AND GATE O	of (marginal)	NAME AND ADDRESS OF	The second secon	Towns In	OF ET ATION		
	21 & State of Funer (Specify)		West	Libe			tery	195	White	Hall	, MD
	How Wil	Dlankit-	>		24	se	Harter scond St	tein M	HY GO 11	NITT -	nc.
	23. PART I Enior the diseases or shock, or heart fillie. CO ATE CAUSE (Final beam o condition lens to gir denth)	e EXEAN	J coort mire					h as cardial or	respiratory a m	est,	Interve Onest
CERTIFICATION	requestistly not conditions, if a y leading to temporalize cause. Enter UNDERLYING CAUSE (Disease or Injury that brillated events resulting in death) LAST	DUE TO (OR A		UENCE OF		-/-	ACK.	TA			May
	PART II Other algoliticant condition	s cont i ling to deal			The unde	rivino	ceuse given in	Part I Jaa W	AS AN AUTOPET _	1.00	
EDICA			MIT I SAME SAMESAN AND STREET			, .		FE	EB 2 11 10	1	VAR AUTOPS VAR ABLE PRI OMPLETION (VI ULATITY
25	DID TOBACCO USE CONTI	DIALITE TO CALISE	OF DEAT	U VE	- F3 NV		111.100000				YE8 2
SICIAN	S WAS SEPREMAID TO MEDICAL EXAMINATE THE 2 X NO	HORPTIAL	26. PLACE	OF DEATI	OTHER:	0/10)				i	V-7-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-
Y PHY	1 FF VEB 2 NO 1 funpation 2 (1 EH/Outpetion 3 FT DOA 4 T Norsing Moma 5 T Residence 8 (1 Other (Specify)) 27. MANNER OF DI ATTI 1 XX Notice 1 Section 1 Investigation 1 Section 1 Investigat										
E O B	of Suicide & Could not be determined	28+ PLACE OF INJU- building, etc. (5	JRY — At hom	ie, 1e:(1), e::				201 LOCATION (S City or Rean	lroot and Number 6 Stare)	r Rumi Roc	ita Number
PAP.	One) 2 [] MEDICAL EXAMINE	TAN: To the best of my kn	iowledge, deal	h occurred	In my opial	dete a	nd place, and due	to the cousa(s) and	f mannar as stoled	1.	
0 11				-	, op/10	ary's	THE STREET STREET	me one and place	e, and due to the	Câuêste) e	nd meniser e
BE CO	200. BIGHATURE AND TITLE OF CERTIFIER						PO LICENSE NUM	DER	29d DATE	5 04 5	OV 16a

FEB 1 5 1995

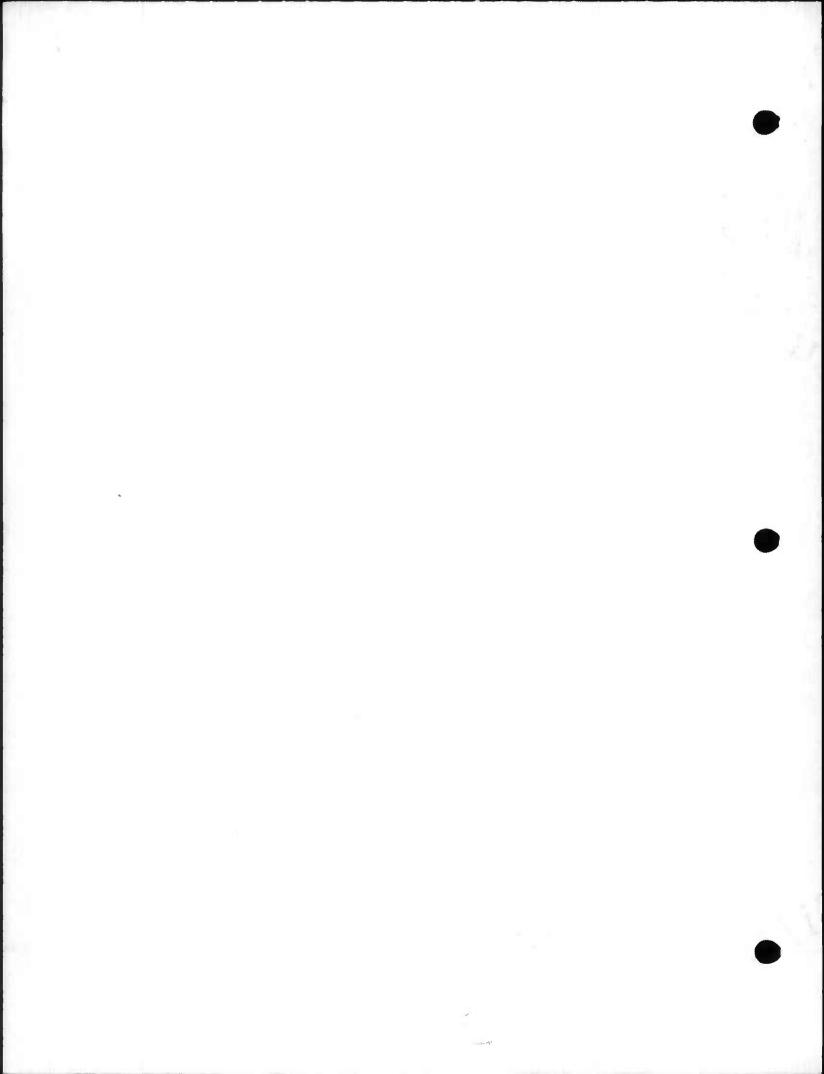
DIVISION OF VITAL RECORDS, P.O. BOX 5876



藤,	-	ł
BALTIMORE, MARYLAND 21215-0020	for death. Page 6 may be retained by the hospital or attending physician. The funeral director, page 5 should be detached for use as the burial-transit loval.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detabled for use as the burial-transit may be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND ME	ENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC	IENT OF H	EALTH AND	MENTAL HYGIEI				
- 6	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN		3	TIME OF DEAT	N
		Lily Maude	DePriest			January 3		5	8:30	PM
	4. SOCIAL SECURITY NUMBER			UNDER t YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year)	8.	BIRTNPL Country	ACE (State or Fo	reign
	180-20-1749	1 □ M 2 😾 F 9		UATS .	HOURS MIN.	May 27, 1	.904		sylvan:	ia
œ	9a. FACILITY NAME (If not institution, give str		96	. CITY, TOWN (R LOCATION OF D	EATN	9c. COUNT	Y OF DEA	TN	
Ē	Wilson Health	Care Center		Gaith	ersburg		Mon	tgom	ery	
EC	10e. STATE 10b. COUNTY		10c. CITY, Ti	OWN OR LOCAT	ION			-10	Dd. INSIDE CITY	
FUNERAL DIRECTOR	Maryland Mo:	ntgomery	Gait	nersbui	q			x	LIMITS?	NO
Y	10e. STREET AND NUMBER				. ZIP CODE	****	10g. CITIZE	N OF WHA	AT COUNTRY?	
5	301 Russell Avenue #437 20877 United								tates	
F	11. MARITAL STATUS 1 X Never Married 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES		13. WAS DEC	ENDENT OF NISPA	NIC ORIGIN? (Specify Y	es or No — 14	Black, V	- American India	n,
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA		2 NO Speci			Specify:	White		
	15. DECEDENT'S EDUC	JAL OCCUPATION	ON .	16b, KIND OF B	USINESS/INDUS	TRY	MILLE			
E	(Specify only highest grade of Elementery/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life, Do NOT use re	done during mo	st of working					
필		4	Teacher			Educa	tion			
COMPLETED	17. FATNER'S NAME (First, Middle, Last)			18. MOTNER'S NA	AME (First, Middle, Maide	n Sumame)				
BE	Fred DePriest			Mary I	Leanord					
5	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or To				
-	Diane E. DePriest	-	10809 R	ock Ru	n Drive,	Potomac,	Maryla	and	20854	
	20b. PLACE AND DATE of DISPOSITION 20b. PLACE AND DATE of DISPOSITION (Name of content), remetery, crametery or other place) 2/4/95 2 2 2 2 2 2 2 2 2									
	4 Donetion 5 Other (Specify) A		. Pleasan		tery	Mt	. Pleas	sant	PA	
- 1	5/1/18	1/ '-	W00046	Rober	A. Pum Chase,	phrey Fune	ral Ho	me/B	ethesda	a-
_	Michael K	wan	M00846	Betnes	sda, Mar	yland 208	14-350	1	Avenue	9
- 1	23. PART i. Enter the diseases, or constant fellure. L	omplications that ceused list only one cause on er	the deeth. Do not sch line.	enter the mo	de of dying, suc	ch ss cardiac or res	piratory erres	it,	Approxima	
	IMMEDIATE CAUSE (Finel	b . A 1							Onset and	Daath
	disesse or condition resulting in death) s. India from the following of t									K5
S	Sequentially list conditions, I b. Alghorners dementia									
¥	use. Enter UNDERLYING									
CERTIFICATION	CAUSE (Disesse or Injury that Initiated events	DUE TO (OR AS A	CONSEQUENCE OF):						1	
F	resulting in death) LAST	J								
	PART II. Other significent conditions	contributing to death by	ut not reculting to t	ha undadular	n neuron eluca la	Best Les Mass		T		
CAL	<u> </u>	- Contributing to death be	or nor resolding in the	ne underlynn	g cause given in	PERFO	N AUTOPSY ORMED?	A	ERE AUTOPSY FII MILABLE PRIOR 1 OMPLETION OF C	ro or
						1 TYES	2 NO	O	F DEATN?	
Σ	DID TOBACCO USE C	ONTRIBUTE TO	CAUSE OF D	FATH Y	ES NO			t	TYES 2	fo
AN	25. WAS CASE REFERRED TO MEDICAL		0.1001 0. 1		ACE OF DEATH (C)					
PHYSICIAN: MEDICAL	EXAMINER? t ☐ YES 2 X NO	HOSPITAL: 1 Inpatient 2 ER/Outpi		THER:		6 Other (Specify)				
ΞÌ	27. MANNER OF DEATN	28e. DATE OF INJURY	28b. TIME O	28c. INJ	URY AT	28d. DESCRIBE HOW	INJURY OCCU	RED		\dashv
ВУР	1 Natural 5 Pending Investigation	(Month, Day, Year)	INJURY		RK? /ES 2 NO					_ 1
	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Speci	— At home, lerm, stree	t, lectory, offic		281. LOCATION (Street City or Town, Stet		Rural Rou	te Number,	
	4 Nomicide determined					ony or lown, ores	-7			
COMPLETED	29e. CERTIFIER (Check only	CIAN: To the best of my knowle	edge, death occurred a	t the Ilme, date	end place, end due	to the ceuse(e) end m	enner ee stated			
ŏ O		R: On the besis of exemination							nd menner ee st	sted.
	296. SIGNATURE AND TITLE OF CERTIFIER	2/1			29c. LICENSE NU	MBER	29d. DATE S	SIGNED (M	lonth, Day, Yeer)	
8	1	CUlms	SC MAT		072	31	A	6	1991	< I
일	JE NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	ATN (ITEM 27) (Type, Pri	nt)					, , , , ,	_
	James R. Mor	ore J. 207	Brooks	s An	e Gail	Mersburg	mi	2	0877	
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIGNA	TURE				9			
	FEB 03 1995 Ju	IN THE STATE OF TH	The state of the s							



205AM

29d. DATE SIGNED (Mopth, Day, Year)

19 95 S

REG. NO

30

2. DATE OF OEATH

29c. LICENSE NUMBER

JAN

DIVISION OF VITAL RECORDS, P.O. BOX 68760.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remon	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medica
2	OR AT	DIREC.	item ?
	SPITAL	NERAL hin 72	NT: IF
	D THE HO	D THE FUI	MPORTA
	-	1	=

BE

1 - FOR STATE REGISTRAR

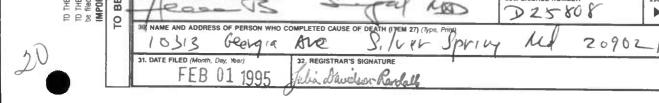
1. DECEDENT'S NAME (First, Middle, Last)

Robert

	1 1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	st birthday)	IF UNDER 1 Y	EAR IF UNDER 24 HRS			8. BIRTHPL/	ACE (State or Foreign	
-		579-46-0519	11 M 2 🗆 F	79	YRS.	ONTHS D	AYS HOURS MIN.	Mar.	20, 1915	Country		
2000		9a. FACILITY NAME (If not institution, give	treet and number)			Db. CITY, TO	OWN OR LOCATION OF			UNTY OF DEAT		
MH2)	DIRECTOR	Holy Cross Hospi	tal			Silv	er Spring		22 (0	tgomer		
MILE	EG.	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	γ		10c. CITY.	TOWN OR I	OCATION			100	d. INSIDE CITY	
	뚬	Maryland Mont	gomery				pring				LIMITS?	
ama.		10e. STREET AND NUMBER	3027		1 522	-	10f, ZIP CODE		10a Ct	TIZEN OF WHA	YES 2 X NO	
sift per	FUNERAL	12732 Middlevale	Lane				20906		109.00	USA	TOOMINIT	
020 physician. bunial-transit	S	11. MARITAL STATUS	12. WAS DECEDEN	IT EVER IN U.S. AF	RMED	13. WAS	DECENDENT OF HISE	ANIC ORIGIN?	Specify Yea or No		American Indian,	
D20 phys buria		1 Never Married 2 Married	FORCES? 1 IF YES, GIVE W	YES 2 X	NO	If yo	YES 2 NO Spe	Ican, Puerto Ric	en, etc.)	Black, W Specify:	hita, atc.	
5-0 anding as the	BY	3 Widowed 4 Divorced				1	The second second	City			Chinese	
after after asses	COMPLETED	15. OECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DE	CEDENT'S U	SUAL OCCU	PATION ng most of working	18b. K	IND OF BUSINESS/IN	IDUSTRY		
Elementary/Secondary (0-12) College (1-4 or 5+)												
ND hospi	₽	12	6	Ь	ibrari	Lan		Li	brary of	Congr	ess	
Ng-Sui Feng Dunn 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surmame) Unobtainable												
11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No- If yea, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — A Black, White 1 YES 2 No Specify: No Specify: Speci												
											1 1 2000	
20s. METHOD OF DISPOSITION 1												
Page dire	ľ	21. BIGNATURE OF FUNERAL SERVICE LIE	ENSEN	- IGate	or nea	22. NAI	WE AND ADDRESS OF	FACILITYHin	os-Rinal	di Eur	, Maryland	
ALTIN death. Page tuneral dir di.	1	1.5	-	P		111	800 New Ha	ampshir	e Avenue	ar rune	star nome	
B fter d the coval.	1	20 2021	Jan	near		J Si	lver Sprin	ng, Mar	yland 2	0904		
B nours after of in by the or removal		23. PART i. Enter the diseases, or shock, or heart fallure.	List only one cau	t caused the de isa on each line	sth. Do no	anter the	e mode of dylng, se	uch ss cardla	or respiratory s	rrast,	Approximsta interval Between	
filled ion, o		iMMEDIATE CAUSE (Final disease or condition	Act	= 1, (a l . a i	M	Vacald.	1-1	1,100	Ma	Onset and Death	
3760, completely filled in nat, cremation, or re		resulting in death)	a. Proces	OR AS A CONSE	erion	1-1	yo cardi	مر اله	Tari	/P]	18 Mr7	
68760. xecuted with and complet burial, cren	_		0	nary	+to	1 wh	219	Pa SP				
~ ° - 2 E	CERTIFICATION	Sequentially list conditiona, if any, leading to immediate	0.	OR AS A CONSE	DUENCE OF):	() /						
BOX cate be en thysician a e prior to	S	cause. Enter UNDERLYING	6								ļ	
D. Entrituded of the state of t	Ĕ	CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CONSE	DUENCE OF):							
		resulting in desth) LAST	d									
RECORDS, P.O. BOX requires that the death certificate be requires that the attending physician to of health and Mental Hyghere prior is shows any injury, or other traun		PART il. Other algnificant condition	s contributing to	death but not r	esulting In	the unde	riving cause given i	in Part I	In. WAS AN AUTOPSY	24b WE	RE AUTOPSY FINDINGS	
RECORDS, requires that the decensioned by the at of Health and Ment shows any Injury.	MEDICAL	Cardioconi		Lock			.,		PERFORMED?	AWA	AILABLE PRIOR TO	
CC ires t signer signer tealth			Uletabol		cido	318		— ¹	YES 2 NO	OF	DEATH?	
TO TOPACCO LIST CONTRIBUTE TO CALISE OF PEATLY VES TO VICE TO SALISE OF PEATLY VES TO VICE TO										YES 2 NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH (Check only one) S. WAS CASE REFERRED TO MFDICAL EXAMINER? 1 YES 2 NO THER: 1 YES 2 NO THER: 1 YES 2 NO THER: 1 YES 2 NO THER: 1 No Natural S DEATH (Check only one) 258. DATE OF INJURY (Month, Dey, Year) 258. DATE OF INJURY AT WORK? 1 No Natural S Describe How Injury Occured Injury (Month, Dey, Year) 258. DATE OF INJURY AT WORK?												
the the	PHYSIC	27. MANNER OF DEATH	28a. DATE OF		28b. TIME		Homa 5 Residence		(pecify)	COURED		
ION OF VDING PHYS I: After this or r death with is marked,		1 Natural 5 Pending	(Month, Di	ay, Year)	INJUR	Y .	WORK?	Zeu. DESCH	IDE NOW INJUNT OF	COMED		
ONG DING After death	B	2 Accident Investigation 3 Suicide & Could not be	28a. PLACE O	F INJURY — At ho	me, farm, atri			281 LOCATI	ON (Street and Number	er or Burni Bouts	Mumber	
VISION ATTENDING ECTOR: After s after death		4 Homicide 8 Could not be	building,	etc. (Specify)	.,,	,,		City or	own, State)	or mover moure	realition,	
OR OR IOUR	COMPLET	298. CERTIFIER A CERTIFYING BUYOU	MAN: To de- 5	and the second of				870 W =				
OSPITAL (UNERAL I	₽ I	29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	R: On the best of	my knowledge, de	my occurred	at the time,	data and place, and do	us to the cause	a) and manner as st	rted.		
1 TOSPITAL TUNERAL WITHIN 72	8	- C MEDIONE EXAMINE	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated.									

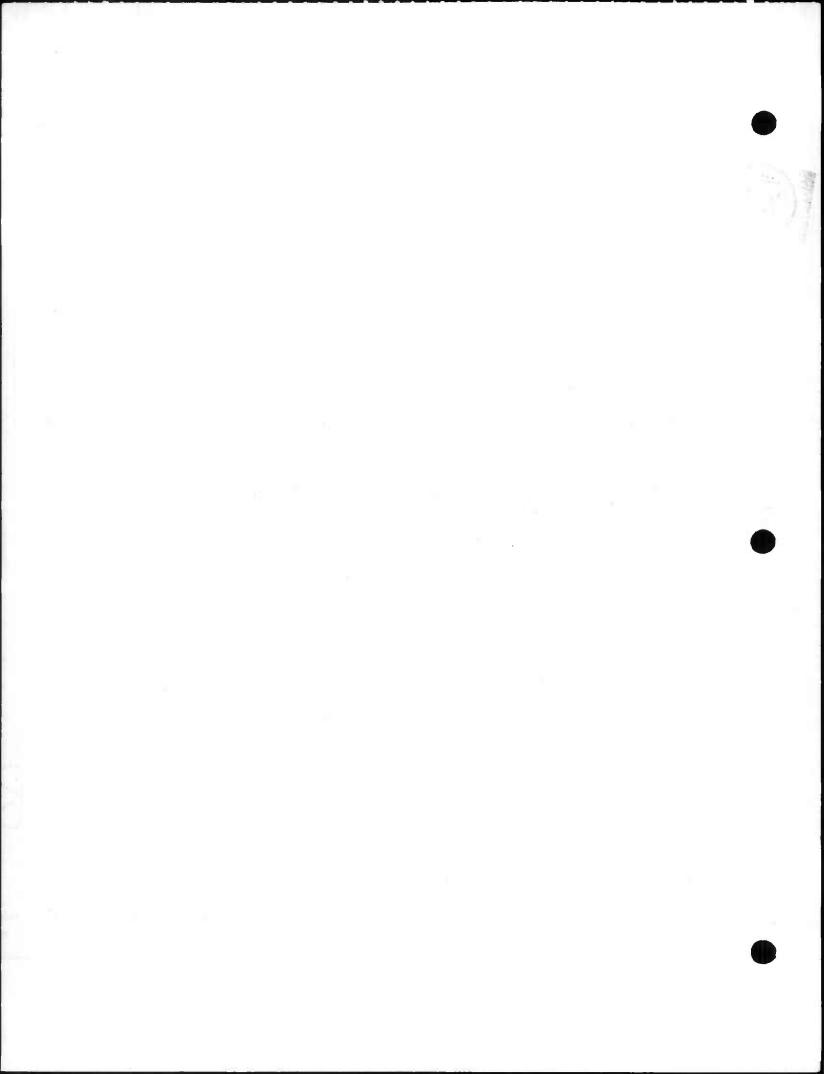
Dunn

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



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DHMH-16 Rev 1/89



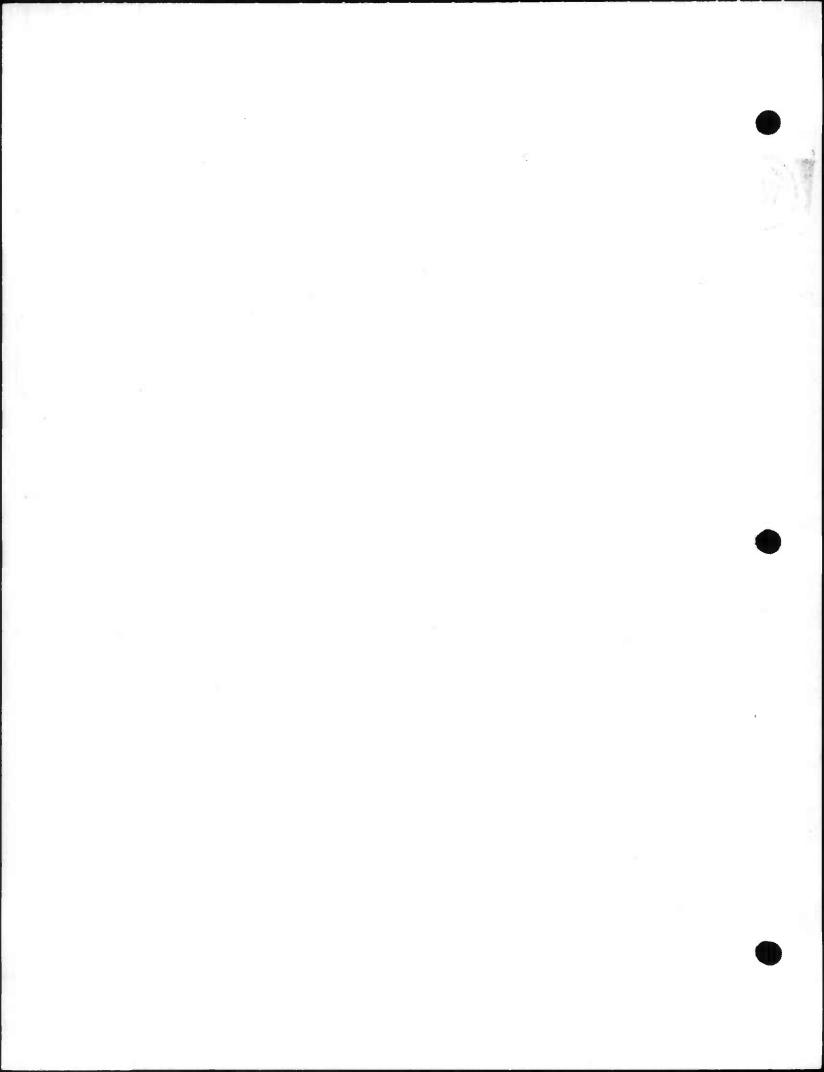
	REGISTRAR			ENTIF	ICALE	IF DE	АІП	REG. N	Ο.			
	00.10	Michael)eFr	ies		2. DATE OF DEATH JANUALI	21 1	995 P	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 218-56-3444	5. SEX 1∑M 2 ☐ F	6. AGE (In yrs. In 46	ynst birthday)	IF UNDER 1 YE MONTHS DA		DER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) July 7,19	48	Country	PLACE (State or Foreign rgia	
	9e. FACILITY NAME (If not institution, give str	reet and number)			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEA						ATH	
DIRECTOR	Shady Grove Advent	tist Hosp	ital		R	ockv	lle		Мо	ontgo	mery	
Ĭ,	10e. STATE 10b. COUNTY			10c. CIT	De. CITY, TOWN OR LOCATION 10d. II							
LDIF	Maryland Mon	ntgomery			Germantown						1 YES 2 NO	
FUNERAL	20032 Frederick Ro	oad, #24									ted States	
	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT FORCES? 1X IF YES, GIVE WA	YES 2	RMED NO	It yee, specify Cuben, Mexican, Puerto Ricen, atc.)						- American Indian, White, etc.	
ВУ	3 Widowed 4 Divorced	Vietn			1	123 2 (2)	о эрвску.			Specify	White	
	15. DECEDENT'S EDUC (Specify only highest grade of		18e. Di	ECEDENT'S	USUAL OCCUP	ATION most of wo	dkina	16b. KIND OF B	JSINESS/IN	DUSTRY		
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)				e retired.)	,	· · · · · · ·		_			
MC	17. FATHER'S NAME (First, Middle, Last)				rch	40.11	OTHERNS ALSO	Westat		earch		
BE C	William A	ries			a D. Crui		ank					
	19e. INFORMANT'S NAME (Type/Print)				ADDRESS (Str		_	oute Number, City or To				
5	Barbara S. DeFries					,Gaithers			20879			
	20b. METHOD QE DISPOSITION 1											
										rev Funeral		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00348 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery A. Rockville, Maryland 20850-2805 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate										ntgomery Ave	
	23. PART I. Enter the diseases, or ci ahock, or heert fellure. L	omplications that	caused the de	eeth. Do n	ot entar the	mode of	dylng, such	ae cerdiec or rea	oiretory ar	rest,	Approximate interval Batween	
}	IMMEDIATE CAUSE (Final											
	resulting in death)	EMPY				ACI!	3				12days	
_			OR AS A CONSE		7):						12days	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate		DR AS A CONSE		ງ:						19000	
₹ I	cause. Enter UNDERLYING CAUSE (Disease or injury											
	thet initiated events resulting in death) LAST	DUE TO (OR AS A CONSE	OUENCE OF):							
H	d d											
	PART II. Other significant conditions	contributing to d	eath but not	reaulting i	n the underl	ying ceue	e given in F			24b. 1	WERE AUTOPSY FINDINGS	
EDICAL	Rend Failur	re; Ad	lutt	Ros	photo	my		PERFO	RMED?		AMAILABLE PRIOR TO COMPLETION DF CAUSE	
ME	Distress Sy	ndrone	Sep	2;2		dio	me	_ ' ' ' ' '	- 500		OF DEATH? 1 X YES 2 □ NO	
	DID TOBACCO USE CONTR		ISE OF DEA	ATH YE	S 🗆 NO		ICERTAIN	1 20				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLA	CE OF DEAT	H (Check only o	ne)						
YSI	1 YES 2 NO	Inpatient 2 🗆	ER/Outpatient 3	DOA	OTHER:	iome 5 🗆	Residence 6	Other (Specify)				
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26e. DATE OF H (Month, Day		26b. TIMI	URY	INJURY AT WORK?	□ NO	28d. DESCRIBE HOW	INJURY OC	CURED		
266 PLACE OF INITIDY - At home from stored testers, add-								28t, LOCATION (Street City or Town, State		r or Rural Ro	ute Number,	
290. CERTIFIER 1 REPRIEVING PHYSICIAN: To the heat of my knowledge death												
291. COATION (Street and Number or Rural Route Number, City or Town, State) 292. CERTIFIER (Check only one) 293. CERTIFIER (Check only one) 294. DOATION (Street and Number or Rural Route Number, City or Town, State) 295. CERTIFIER (Check only one) 296. CERTIFIER (Check only one) 297. CERTIFIER (Check only one) 298. CERTIFIER (Check only one) 299. CERTIFIER (Check one) 299. CERTIFIER (Check one) 299. CERTIFIER (Check one) 299. CERTIFIER (Check one) 299. CERTIFIER (Check one) 299. CERTIFIER (Check one) 299. CERTIFIER (Check one) 299. CERTIFIER (Check one) 299. CERTIFIER (Ch										end manner es stated.		
29c. LICENSE NUMBER 29d. DATE SIGNED (Morith, Day, Year)												
٩	AME AND ADDRESS OF PERSON WHO		OF DEATH (ITE		Print)		1	1 0 4		-1-1-4	ر ۱۱۱۱ رم و	
	31. DATE FILED (Month, Day, Year)	en Derge	S SIGNATION	62	20	ne	yend	e redi	ca,	Thee:	8 buy Kg	
	JAN 26 1995		welson R	irdall								
	1000	()										

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. De filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

DHMH-16 Rev 1/89



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		FOR			
1		STATE			

	1 - STATE REGISTRAR	STATE OF MA			CATE (MENTA	HYGIEN REG. NO		7	1
	1. DECEDENT'S NAME (First, Middle, Last) JOAN Sha	lw	DIK	KSE	N			2. DATI		9	95	3. TIME OF DEATH
- TRANSF	4. SOCIAL SECURITY NUMBER 213-50-6017	1 □ M 2 🂢 F	AGE (In yrs. lest			YS HOUR		Sep	t. 14		8. BIRTI	
TOR	98. FACILITY NAME (If not institution, give s Fernwood House RESIDENCE OF DECEDENT	treet and number)			9ь. стту, то Ве	www.on.coc chesda		EATH		Montgomery		
DIRECTOR	10e. STATE 10b. COUNTY D. C.	1			ashin					10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	3824 gartield St				10f. ZIP C	DDE 007				S.A.	WHAT COUNTRY?	
B⊀	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 X NO Specify:											
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 4 16a. DECEDENT'S SUBJAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Writer 16b. KIND OF BUSINESS/INDUSTRY JOURNALISM											
BE CON	17. FATHER'S NAME (First, Middle, Lest) Elwyn Shaw 18. MOTHER'S NAME (First, Middle, Melden Surneme) Edith Griffin											
TO	19th. INFORMANT'S NAME (TypesPrint) Richard Wayne Dirksen 19th. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 3824 Garfield Street, N.W. Washington, DC 20007											
	20e. METHOD OF DISPOSITION 1											
	· Kunon	S	nmo	0		seph enue,			Sons,	Inc.	513 2001	0 Wisconsin
	23. PART I. Enter the diseases, or calculate the diseases, or calculate the disease or condition resulting in death)	complications that c List only one ceuse	eused the der	ith. Do no	0	mode of \mathbb{N}				iratory ar	rest,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OF	MIDD R AS A CONSEQ R AS A CONSEQ R AS A CONSEQ	LE DENCE OF	CERS RTEI	BRA	L	INF	ARCT			80 days
CAL		S contributing to de NIC OBS	TRUCT	345					24s. WAS AN PERFOR	RMED?	248	MERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN: MED	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	R/Outpatient 3	□ DOA	OTHER:	6. PLACE OF	5.97					
ву РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident investigation	28a. DATE OF IN. (Month, Day,	Your)	28b. TIME INJU	JRY M 1	INJURY AT WORK?	□ NO		SCRIBE HOW I			
ETED	3 Suicide 6 Could not be determined	28e. PLACE OF II building, etc	:. (Specify)					City	CATION (Street of Town, State)			Route Number,
COMPLETED	(Check only one) 2 MEDICAL EXAMINE											a) and manner as stated.
BE (296. SIGNATURE AND TITLE OF CERTIFIER	ack, 1	Wa C	D	37678	29c. L	ICENSE NU	MBER		29d. DAT		(Month, Day, Year)

25.		MINE	HEFERRED	то	MEDICAL
	1 🗆	YES	2 NO		
27.	MAN	NER C	F DEATH		

2

)37678 MARYLANO

WESTERN SVA

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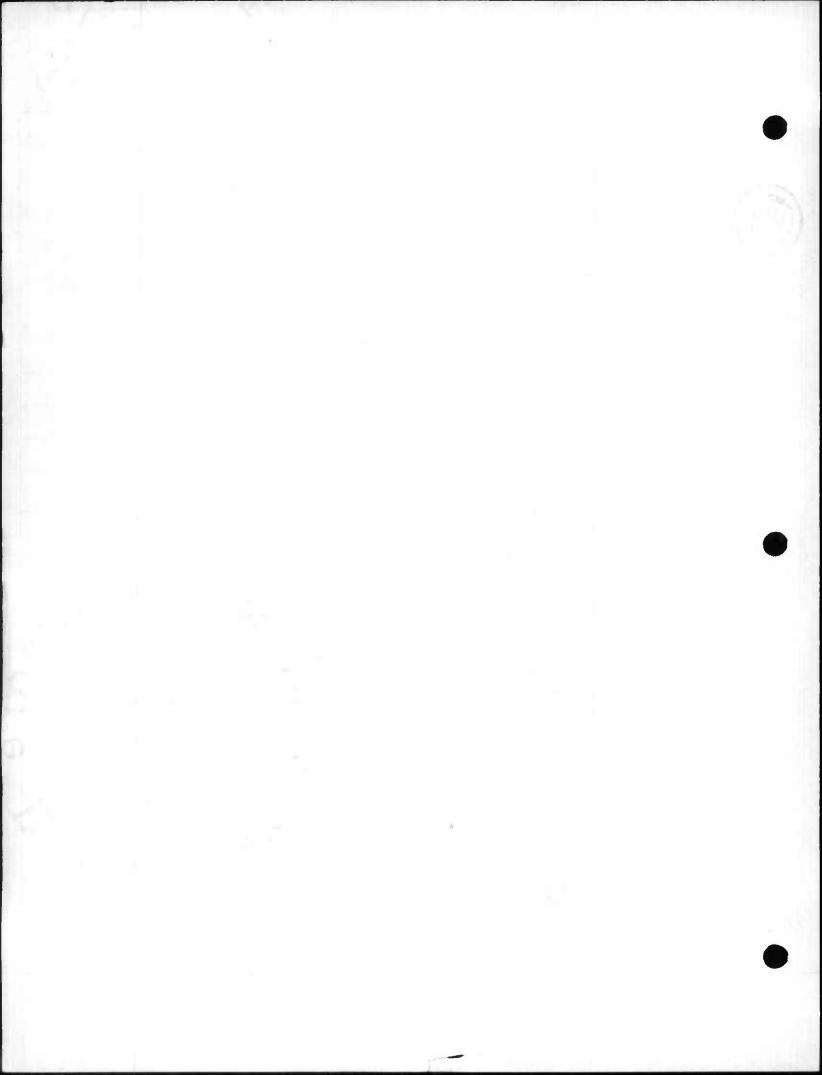
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Hem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020



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777	e hospital or attendin	etached for use an III		nca.
	6 may be retained by th	tor, page 5 should be o		nust be notified at o
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the	, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
	be executed within 24	ician and completely fill	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	traumatic event, the
	hat the death certificate	d by the attending phys	and Mental Hygiene pi	ny injury, or other i
	IAN: The law requires t	tificate has been signer	e State Dept. of Health	or item 23 shows a
	R ATTENDING PHYSICI	RECTOR: After this cer	urs after death with th	m 28 is marked, o
	TO THE HOSPITAL OI	TO THE FUNERAL DIS	be filed within 72 hox	IMPORTANT: It ite

MRT Montgomery County Amended #1 2/2/95
FOR STATE OF MARYLAN

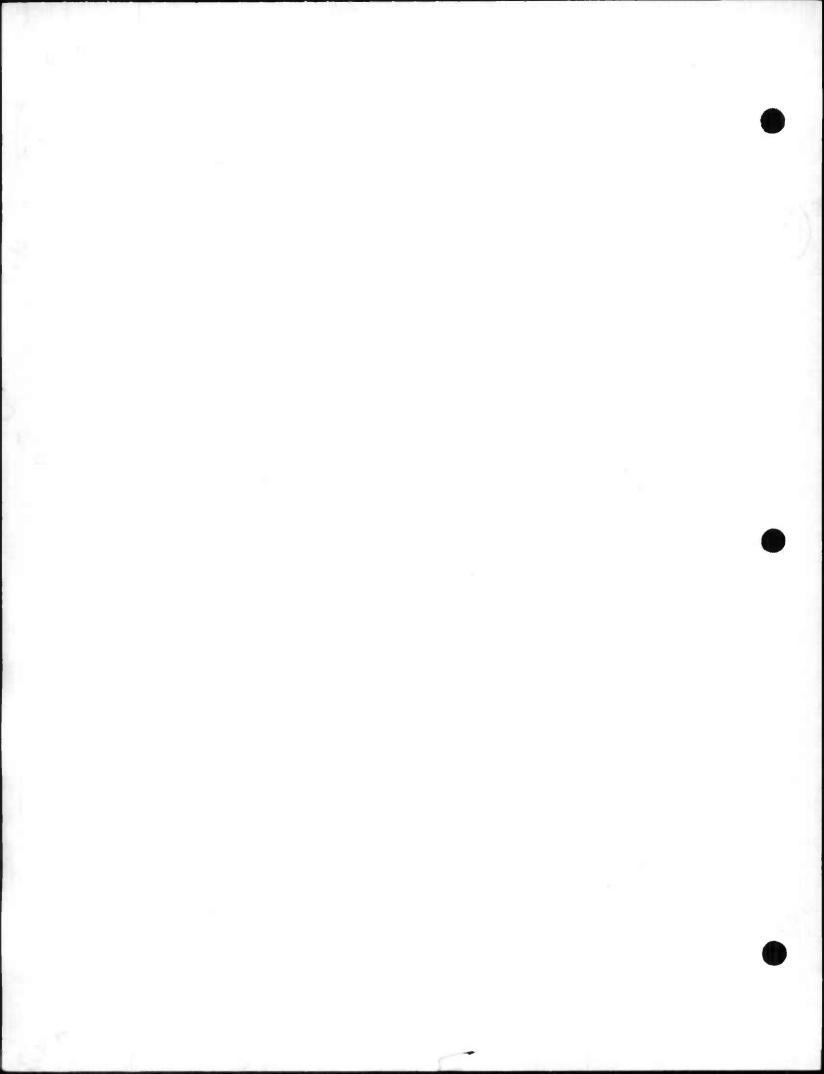
	1 - STATE REGISTRAR	SIAIL OF MIAI	CEF	RTIF	ICATE OI	F DEAT	TH	MENIA	REG. NO			0	
	1. DECEOENT'S NAME (First, Middle, Last)	W. Leo	T	7	nova			MONT	OF DEATH	MY o	YEAR	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last bir		IF UNDER t YEAR			0		29	95	1:38 PM	
Á	220-44-3119	t√XM2□F		YRS.	MONTHS DAYS		MIN.	(Month	OF BIRTH h, Day, Year)	20	Country		
	9a. FACILITY NAME (If not institution, give s				9b. CITY, TOWN	OR LOCATI	ON OF DE		1 190		Was	hington, DC	
DIRECTOR	Suburban Hospital				Bethe		0				ntgor		
EC	10a. STATE 10b. COUNT	1	10c. CIT	Y, TOWN OR LOC	ATION						10d. INSIDE CITY		
	Maryland Mont	gomery		Be	thesda				LIMITS				
AL	10e. STREET AND NUMBER				1	IOF. ZIP CODE	E			10g. CIT		THAT COUNTRY?	
FUNERAL	8016 Old Georgeto					2081	.4			U.	S.AS		
BY FU	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVEN FORCES? 1 X IF YES, GIVE WAR O WORLD WAR	YES 2 NO	D	17 yes, s	ECENDENT Of the second of the	ıп, Mexica	an, Puerto F	I? (Specify Yes Rican, etc.)	s or No—	Black, Specify		
	15. DECEDENT'S EDU			DENT'S	USUAL OCCUPAT	PIONI		1405				hite	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)		(Give k	kind of v	work done during n	ost of working	ng	100.	. KIND OF BU	SINESS/INL	JUSTRY		
APL		5+ Medical Doctor Medicine											
S	17. FATHER'S NAME (First, Middle, Last)						HER'S NA	ME (First, A	Hiddle, Maiden	_			
BE (John Dennis Don	iovan						n Bro					
2	19a. INFORMANT'S NAME (Type/Print)		19b. M.	AILING	ADDRESS (Street	and Number	or Rural F	Route Numb	er, City or Tow	n, State, Zic	Code)	2017	
٦,	Dorothy M. Dono	van			Old Geo		wn K	loaa	Bethes	sda,	MD Z	J814 	
	20s. METHOD OF DISPOSITION 1 Burlel 2 Crematton 3 Rem 4 Donation 5 Other (Specify)	ioval from State	cemetery, cremato	tory or ot	OF DISPOSITION (F			OATE			City or Tow		
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	Mount	Com	110rt Cr	emato		2/6	Al	exanu	lria,	VA	
ì	· Vinhs	m Ve	ters		Josep	h Gaw	ler'	's So	ns. Ir	nc. 5	130 1	Wisconsin	
-	23. PART/I. Enter the diseases, or o	complications that or	- d the death	20.	Avenu	e. NW	/ Was	shing	ton. I	DC 20	016		
	snock, or neart failure.	List only one cause	on each line.	. DO 11	lot enter tha m	oda or dyi	ng, sucr	h aa card	lac or respi	ratory arr	est,	Approximata interval Between	
	iMMEDIATE CAUSE (Fine) disease or condition	/1	a.t.	-(rede		11	Khu	Onset and Death				
	resulting in death)	DUE/TO/LOR	AS A CONSEQUEN	NCE OF			1	1	-		limus		
z	C.	· Ca	roxer	y.	140	ero	+ N	lisi	use			15 man	
CERTIFICATION	Sequentially list conditions, If any, leading to immediate	OUE TO (OR	AS A CONSEQUE	MOE OF	7		_					1	
5	cause. Enter UNDERLYING CAUSE (Disease or injury	c	AS A CONSEQUEN	J									
	thet initieted events resulting in death) LAST	502 10 (011	AS A CONSEQUE	NUE UF	7:								
빙	21771 01 11	d											
룅	PART ii. Other significant condition	e contributing to dea	ith but not resul	ulting i	n the underlyle	ig ceuse g	ivan in l	Part i.	24s. WAS AN PERFOR		- 7	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
								-	1 - YES 2	MA		COMPLETION OF CAUSE OF DEATH?	
WE	DID TOBACCO USE CONTR	DIRLITE TO CALIC	E OE DEATH	VE	1 OK 🗆 3	7 11116	EDTAIN				1	1 TYES 2 NO	
SICIAN:	25. WAS CASE REFERRED TO MEDICAL	(IBOTE TO CAUSI			H (Check only one		ERTAIN	4 📙					
္ဗ	EXAMINER? 1 YES 2 NO	HOSPITAL:	VOutpetient 3 🗆 🖸		OTHER:		aldamas	a 🗆 Orber	15				
PH	27. MANNER OF DEATH	28a. DATE OF INJU	URY 28	86. TIME	E OF 28c. IN	JURY AT	SIGNIC .		CRIBE HOW II	NJURY OCC	CURED		
BY	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye	ser)	INJU		ORK? YES 2 _] NO						
	3 Suicide 8 Could not be	28e. PLACE OF INJ building, etc. (JURY — At home, (Specify)	ferm, a	itreet, factory, offi	ce		28f. LOCA	ATION (Street a or Town, State)	and Number	or Rural Ro	ute Number,	
	4 Homicide determined												
MPLET		CIAN: To the best of my k											
o S	MEDICAL EXAMINE	R: On the basis of examin	nation and/or inves	atigation	in my opinion,	death occurr	ed at the t	time, date a	and place, en	d due to the	e cause(a)	and manner as stated.	
H B	296 SIGNATURE AND TITLE OF CERTIFIER	26	H	12		29c. LICE	NSE NUM	BER GULO	/	29d. DATE	E SIGNEO (Month, Bay, Year)	
2	30. HANE AND ADDRESS OF PERSON WHO	103/1	au i	ne	W	100	-/	748		10	1/2	9/95	
	30. HAME AND ADDRESS OF PERSON WHO	resid the	E DEATH (ITEM 27)	Type	ethis,	da,	Ma	ery,	lano	l.			
ı	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S S	SIGNATURE				-	1					
	FEB 02 1995	Julia d'avel	101- Rardall	,				V					

BALTIMORE, MARYLAND 21215-0020

2, 3 should

TO BE COME	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	TO THE CHREGAL MIDENTAL AND A MARK this has been singled to the seasonal and the seasonal seasona seasona seasona seasona seasona
r death. Page 6 may be retained by the host	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hose

	1 - STATE REGISTRAR	OIRIE OI II	CE	RTIF	ICAT	E OF	DEAT	TH C	MENIAL	REG. NO.			
	1. DECEOENT'S NAME (First, Middle, Lest) CARL A.	DOMSKI							2. DATE OF MONTH Janua	DEATH	, 1º	VEAG	3. TIME OF OEATH 8:00 A M
	4. SOCIAL SECURITY NUMBER 089-12-7115	5. SEX 1 ⊠ M 2 □ F	6. AGE (In yrs. last		IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF (Month, D Sept.	BIRTH (av. Wear)	1922	8. BIRTHE	LACE (State or Founds)
LOR	9a. FACILITY NAME (If not institution, give Montgomery Gener	,	al			ney	R LOCATIO	ON OF DE			9c. COU	t gome	ATH
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	ΓY		10c. CIT	Y, TOWN (OR LOCAT	ION					T	10d, INSIDE CITY
		gomery		Si	lver	Spr	ing					- 1	LIMITS?
FUNERAL	15424 Aylesbury	Street				101.	ZIP CODE					SA	HAT COUNTRY?
B	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W		WED O		If yes, spe	ENDENT O	F HISPAN n, Maxican Specify	IC ORIGIN? (Specify Yas an, etc.)	or No-	14. RACE Black, Specify	- American Indian, White, atc.
E	15. DECEDENT'S EDI (Specify only highest grad	UCATION	16a. DEC	CEDENT'S	USUAL O	CCUPATIO	N and a secondaria		16b, KI	ND OF BUS	INESS/IN	DUSTRY	WIIICC
COMPLETED	Elementary/Secondary (0-12) 12	College (1-4 or 5 +	·) life.	Sale:	se retired.)	auning mos	st or workin	9		Photo	ogra	phic	
8	17. FATHER'S NAME (First, Middle, Lest)								ME (First, Mide		Surname)		
B	Stanley Domski 190. INFORMANT'S NAME (Type/Print)			1414 414					ozinsk				
2	Sonya S. Domski								oute Number, , Sil				20905 aryland
	20a. METHOD OF DISPOSITION 1 2 Burlal 2 Cremation 3 Ren 4 Donation 5 Canar (Specify)	noval from Stata	20b. PLACE A cometery, crem	natory or o	ther place)				OATE	(City or Tow	•
1	21. SIGNATURE OF FUNERAL SURVICE LI	СЕНВЕЕ	Gate o	OI HE	22.	NAME AN	DADDRES	S OF FAC	1/31	Silv	er S	pring	, Maryland neral Home
	+ 16il €	Kins	2			.1800 S il ve) New er Sp	Han ring	npshir g, Mar	e Ave	enue 1 20	0904	neral nome
	23. PART i. Enter the diseeses, or ahock, or heart failure.	complications that List only one cau	t ceused the dea se on each line.	ath. Do i	not enter	the mod	de of dyle	ng, auch	aa cardlad	or reaple	ratory ar	reat,	Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	. Sep	sis							_			Onset and Death
N	Sequentially list conditions,		Creak		F):	an	ce	6					3 mo
CATIC	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	OUE TO	(OR AS A CONSEQ	UENCE O	F):								
CERTIFICATION	that initiated events resulting in death) LAST	DUE 10 (OR AS A CONSECU	UENCE O	F):								
	PART II. Other algnificant condition	na contributing to	death but not re	sulting	In the un	derlying	cause g	iven in F	Pert I. 24	a. WAS AN			WERE AUTOPSY FINDINGS
EDICAL									1	PERFORI	1		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
A: ME	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEAT	H YE	SΠN	ио П	UNC	ERTAIN				1	1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			TH (Check o	only one)							
YSI	1 - YES 2 - NO	1 Inpatient 2 II		DOA	OTHER		5 🗆 Red	idence (6 🗆 Other (S	pecify)			
ВУ РН	27. MANNER OF GEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF (Month, Da	INJURY iy, Year)	28b. TIM INJ	E OF URY M	28c. INJU WOF 1 Y			28d. DEŞCR	BE HOW IN	JURY OC	CURED	
	3 Suicide a Could not be determined	28s. PLACE Of building,	FINJURY — At horr itc. (Specify)	e, larm, s	street, facto	ory, office			261. LOCATIO	ON (Street ar	nd Number	or Rural Ro	ute Number,
COMPLETE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS	ICIAN: To the best of a											
S	296. SIGNAPURE AND TITLE OF CERTIFIE		1			J. 1	29c. LICEI			prace, and			Month, Day, Year)
TO B	Justen 4	#//	Bu	M	0		pz	27	73				y 27, 1995
	Dr. Frederick Ba		4 Wiscon			nue,	#134	45, (Chevy	Chas	e, M	D 20	815
	31. DATE FILED (Month, Day, Year) FEB 01 1995	32. FEGISTRAF	r's signatures	fall									



YGIENE	1	
EG. NO.	V	

	REGISTRAR		CERT	FICATE	OF	DEATH	H	EG. NO.		(/	
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DEATH			3. TIME OF DEATH	
	Winifred Dalton	LR. Da	Itan				MONTH 1	3		95	11:00 A	М
	4. SOCIAL SECURITY NUMBER		NGE (In yrs last birthda	y) IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATE OF E	WRTH		8. BIRTHE	LACE (State or Foreign	
	082-38-8797	1 🗌 M 2 💢 F	91 YAS	MONTHS	DAYS	HOURS MIN.	June 2		L903	Country	York	
	9e. FACILITY NAME (If not institution, give st	reet and number)		9b. CITY,	TOWN C	R LOCATION OF DI		د رب.		INTY OF OE		
٣	Brooke Grove Reha	b & Nursin	g Center		lnev							
5	RESIDENCE OF DECEDENT									поту		
DIRECTOR		10d. cl 11, Town Or Location									10d. INSIDE CITY LIMITS?	
ā	,	laryland Montgomery Olney									1 YES 2 NO	
A	10e. STREET AND NUMBER				101.	ZIP COOE			10g. CIT	IZEN OF W	HAT COUNTRY?	
빌	18430 Brooke Grov	e Road				20832			Uni	ted S	States	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. ARMED	13, V	NAS DEC	ENDENT OF HISPAN	NIC ORIGIN? (S	pecify Yes	or No-	14. RACE	- American Indien,	
BY F	1 Never Merried 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR				city Cuben, Mexice 2 X NO Specif		, etc.)		Black, Specify	White, etc.	
						^					ite	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT	of work done of use retired.)	CUPATIO	IN st of working	16b, KIN	D OF BUS	SINESS/IN	DUSTRY		
	Elementary/Secondary (0-12)	College (1-4 or 5+)				100000						
MP	12	5	Teache	r				cati				
	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA						
BE	William Regan							lcCar				
2	19e. INFORMANT'S NAME (Type/Print)					nd Number or Rural					2075	
	Mary Anne Tuohey				-	Street,						
	20e. METHOD OF DISPOSITION 1 Y Burial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	oval from State	20b. PLACE AND DAT	r other place)			DATE			City or Tow		
1	1 St. Datifier S conlectly 2-4 Offerda, New 101									York		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A.											
	(Men)	W. Ka	pp								MD 20910	
	23. PART I. Enter the diseases, or c	omplications that car	used the deeth. De								Approximete	
	ehock, or heert fellure. I IMMEDIATE CAUSE (Finel	List only one ceuee o	n eech line.								Interval Betwee	
	disease or condition	Pnen	monia								2 weeks	er1
	resulting in death)	9	AS A CONSEQUENCE	OF):							- 4000108	
,	_										j	
CERTIFICATION	Sequentielly list conditione, if any, leeding to immediate	DUE TO (OR	AS A CONSEQUENCE	OF):							1	
A	cause. Enter UNDERLYING											
Ĕ	CAUSE (Disease or Injury thet initieted events	DUE TO (OR	AS A CONSEQUENCE	OF):								-
F	resulting in death) LAST	1.										
	PART II Other stanistics and dist	and the state of	. K. A. 1937									
DICAL	PART II. Other algnificent conditions	contributing to dee	in but not resultin	g in the un	derlying	ceuse given in	Part I. 24a	. WAS AN PERFOR	AUTOPSY MED?	-	WERE AUTOPSY FINDING AVAILABLE PRIOR TO	
	n							YES 2	X NO		COMPLETION OF CAUSE OF DEATH?	
ME											TO YES ZXXNO	
ž	DID TOBACCO USE (CONTRIBUTE T	O CAUSE C	OF DEAT	ГН Ү	ES NO						
PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		CTIT		ACE OF GEATH (Ch						
YSI	1 TES 2 XNO	1 Inpellent 2 ER/	Outpetient 3 🗆 DOA	4 X Nurs	ing Home	5 🗆 Residence	8 Other (Spi	ecify)				
H	27. MANNER OF DEATH	28e. DATE OF INJU (Month, Day, Ye		IME OF	28c. INJU	JRY AT	28d. DESCRIE	E HOW II	NJURY OC	CURED		
BY	1) Natural 5 Pending 2 Accident Investigation		-1-0	М		ES 2 NO						
- 11	3 Suicide 8 Could not be	28e. PLACE OF INJ building, atc. (URY - At home, ferr	n, atreet, facto	ory, office		281. LOCATION	N (Street a	ind Numbe	r or Rural Ro	ute Number,	
	4 Homicide datarmined						J.17 55 101	, 514(0)				
COMPLETED	29e. CERTIFIER (Check only	CIAN: To the best of my k	nowledge, death occu	irred at the til	me, date	end place, end due	to the cause(e)	end men	ner ee ste	ted.		
M	one) 2 MEDICAL EXAMINER										end manner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER	··-			1						1/ 1/	
8	296. SIGNATURE AND TITLE OF CERTIFIER 296. D33700 296. DATE SIGNED (Month, Day, Year) 1-31-95											
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	DEATH (ITEM 27) (E	ne Printl		000700				- 31-		_
	Ted E. Howe, M. D.		ade Schoo		C-	india Com	ing Mr) 0/	1060			
	31. DATE FILEO (Month, Day, Year)	32, AEGISTRAR'S	AGNATURA A	n Ku.	36	indy Spr	ing, ML) 2(טמטע			_
	FEB 02 1995	July Dave	Such Randall									

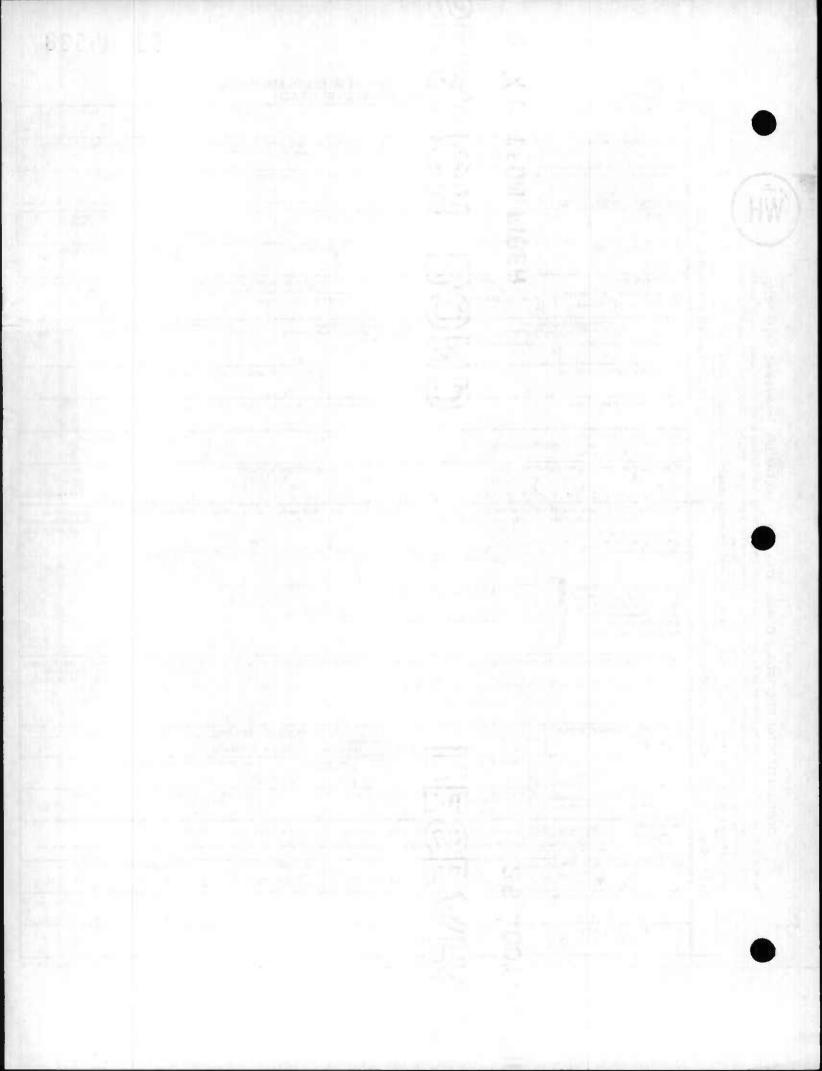


DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1	-	_	2	
	BALTIMORE, MARYLAND 21215-0020	rours after death. Page 6 may be retained by the hospital or attending physician.	d in by the funeral director, page 5 should be detached for use as the burial-transmit permit or removal.	medical examiner must be notified at once.
	DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Jours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-travent permit be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTA	L HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					MONT	OF DEATH	YEA	R	IME OF DEATH	н
	Mary Ruth Dean 4. SOCIAL SECURITY NUMBER						ary 26.		_	4:30	PM
			(in yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		OF BIRTH h, Day, Year)	B. Bi	RTHPLAC ountry)	E (State or For	reign
	577-01-1810 9a. FACILITY NAME (If not institution, give str	1 M 2 F	79 YRS.		OR LOCATION OF D		h 6,191	5 Wa		gton, I	O.C.
DIRECTOR	Randolph Hills Nu	irsing Home		Wheator	1			Mont	gome	ry	
S	10a. STATE 10b. COUNTY	73	10c. CITY,	TOWN OR LOCAT	TION				10d.	INSIDE CITY	
8	Maryland N	Montgomery		Wheator					130	LIMITS?	NO
	10e. STREET AND NUMBER	TOTT CHOME I			. ZIP CODE		1	log. CITIZEN (24		
3	12410 Dalewood Dri	ivo			2090	6		U.S			
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DEC	ENDENT OF HISPA		12 (Specify Veg or			merican India	
BY FL	1 Never Married 2 Married 3 X Widowed 4 Divorced	FORCES? 1 YES	ecity Cuban, Maxic 2 X NO Speci	an, Puerto I		S	Hack, Wh pecify:	ita, etc.	н,		
	15. DECEDENT'S EDUC	ATION	Late DEGERENCE			Lin			nite		- 1
COMPLETED	(Specify only highest grade of	completed)	(Give kind of wo	ork done during mo	st of working	166	KIND OF BUSIN	ESS/INDUSTR	T		
7	Elementary/Secondary (0-12)	College (1-4 or 5+)	1	177							
M	12		Telephor	ne Opera			elephor				100
	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N.			rname}			
BE	Francis P. Cannor	1			Lydia						
2	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	and Number or Rural	Route Numi	ber, City or Town,	State, Zip Code)		
-	Mary R. Wilson		12410	Dalewoo	d Drive	Whe	aton. M	faryla	nd	20906	
	20a. METHOD OF DISPOSITION 1 GrBurial 2 Gremation 3 Remove		. PLACE AND DATE OF	F DISPOSITION (NE		DAT		TION — City o			
	4 Donation 6 Other (Specify)		netery, crematory or oth rt Lincol	er place) n. Ceme t	erv 1	/31/9	5 Brent	Wood 1	Mary	land	
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE	L DINCO	22. NAME A	NO ADDRESS OF F	ACILITY	J IDI CIII	WOOd	Idiy	Letild	
	1 . 11.	en C			s J. Co.						
	many	J. Couph	un_	500 Ur	iversit	y Blv	d. W. S	il.Sp	r. M	D 2090)1
	23. PART I. Enter the diseases, or co shock, or heart failurs. L	emplications that cause ist only one cause on a	d the death. Do no	ot antar the mo	de of dying, su	ch as card	diac or reapirat	tory srrest,	1	Approxima	
	IMMEDIATE CAUSE (Final	-11-2			_				- 1	Onset and	
	disease or condition resulting in death)	Car	- dio vi	so cul	0.5	Do	2 ps	0 .	31		
	resorting in deathy		A CONSEQUENCE OF						-		
7											
CERTIFICATION	Sequentially list conditions, If any, lasding to immediate	DUE TO (OR AS	A CONSEQUENCE OF)	:					1		
X	cause. Enter UNDERLYING								. !		
Ĕ	CAUSE (Disesse or Injury that Initiated events	DUE TO (OR AS	A CONSEQUENCE OF)	:	-						
E	resulting in death) LAST										
8									-		
AL	PART II. Other significant conditions				g cause given ir	Part I.	24s. WAS AN AU			E AUTOPSY FIN	
3	Frace		Him.				PERFORMI		COM	PLETION OF C	
			0				1 1 120 2 2	1 10		DEATH?	
Σ									1 _	YES 2 X N	10
A	25. WAS CASE REFERRED TO MEDICAL										
2	EXAMINER?	HOSPITAL:		OTHER:	ACE OF DEATH (C	heck only or	10)				
YS		1 Inpetient 2 ER/Out			e 5 🗆 Residence	6 🗆 Othe	r (Specify)				
PHYSICIAN: MEDIC	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. IN.	PURY AT PRIC?	28d. DES	CRIBE HOW INJ	URY OCCURE)		
BY	1 Natural 5 Pending 2 Accident Investigation	Sept.26,19			A	Fe11	Down				
	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, etc. (Spe	/ — At home, farm, at	reet, factory, offic		281, LOC	ATION (Street and or Town, State)	Sumber or Ry	Poute	Number, T)ri 177
밑	4 Homicide detarmined	At Home	"				eaton.			wood D	1110
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my know	rledge, death occurrer	t at the time date	and place, and du			_			
2	onel	1: On the basis of axemination							na/a) and	manner on el	mtad
8				, ar my opinion, c		o timo, cata	and prace, and	300 10 110 020	(-)	THE INTER SEC.	aneu.
BE	296. SIGNATURE AND TITLE OF CERTIFIED	70	G V	~	29c. LICENSE NU	IMBER	1 10 2	9d. DATE SIG	NED (Mon	th, Day, Year)	
	Och	Jank	- He	177	7500	67	46	De.	- 0	77.	21
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)				C	3e -	Tura	
	a ha) au se	205	8 >	8 W	15	cons	110	Acx	9	0.4
	31. DATE FILED (MONTA POSTION)	32. HEGISTRAR'S SIGN	NATURE		- ~		V3				MANY.
	JAN 91 1995	John diwel	ion Fordall								



DHMH-18 Rev 1/89

1 -	FOR STATE REGISTRAR

			CE	=n r	ICALL	OF DEA	NI H		REG. NO.				
1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH										. TIME OF DEATH			
Carl Marion Deavers 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F											995	2:15 P M	
		1. M 2 F		t birthday) YRS.	IF UNDER	DAYS HOURS	MIN.	7. DATI	e OF BIRTH 1	900	Country)	ACE (State or Foreign	
578-05-6870		**	86	i na.					ust 17,			ngton,D.C.	
14660 Kelmscot Drive Silver							Spring Sc. county of Death Spring Montgomery						
RESIDENCE OF DECEDENT													
Maryland Montgomery											10d. INSID		
10e. STREET AND NUMBER	Hon	Lgomery			511V	er Spri				10- CITITI		T COUNTRY?	
14660 Kelms	cot Dr	ivo				301 -110 -11	906				U.S.		
11. MARITAL STATUS	COL DI		T EVER IN U.S. AR	MED	13. 1			VIC ORIG	IN? (Specify Year)				
1 Never Married 2 3 Widowed 4 Divo		FORCES? 1				yes, specify Cub	en, Mexica	n, Puerto	Rican, etc.)	Black, Whita, etc. Specify:			
15. DEC	EDENT'S EDUC	ATION	16a. DE	CEDENT'S	USUAL OC	CUPATION	_	16	b. KIND OF BUSI		hite		
(Specify onl) Elementary/Secondary (0	highest grade	College (1-4 or 5 -	(Gi		work done r	uring most of work	dng	1	D. KIND OF BOOK	14633/11400	om		
12	-			c Bin	der	Foreman			Printi	ng			
17. FATHER'S NAME (First, M.	iddle, Last)						THER'S NA	ME (First,	Middle, Maiden S				
William Hen	ry Dea	vers					Elsie	L.	Cur	tin			
19a. INFORMANT'S NAME (7)	rpe/Print)		191	. MAILING	ADDRESS	(Street and Numb	or or Rural I	Route Nur	mber, City or Town,		Code)		
Esther Stor	У		26	511 U	rban	a Drive	Sil	Lver	Spring	,Mary	land	20906	
20a. METHOD OF DISPOSITION 1 Surial 2 Cremetto 4 Donation 8 Other	n 3 🗆 Ramo	val from State	20b. PLACE A	ND DATE	OF DISPOS	FION (Neme of		DA		ATION - CI	lty or Town,	, Stata	
21. SIGNATURE OF FUNERAL		ENSEE	O	11111	22.1	AME AND ADDR	ESS OF FA	CILITY	95 [Sult.	land,	Mary	y Land	
► (Ino	reu)	J. (6	le		Fr	ancis J	. Col	llin	s Funera			Inc. MD 20901	
23. PART I. Enter the di	seasea, or c	omplications tha	caused tha de	ath. Do n	not anter	ha mode of d	ying, auci	h aa ca	rdiac or raapire	tory arre	Bt,	Approximata	
IMMEDIATE CAUSE (Fin		lat only one cau	se on each line										
		1										Interval Between Onset and Death	
disease or condition resulting in death)	→ ,		dial fai				_						
	→	DUE TO	(OR AS A CONSEC	DUENCE OF	F):								
resulting in death) Sequentially list conditi	ona, f	OUE TO	OR AS A CONSEC ry Arter	y Di	seas	2							
Sequentially list condition in any, leading to immediate. Enter UNDERLY!	ona, diate	Corona	(OR AS A CONSEC TY Arter (OR AS A CONSEC	Y Di	seas	2							
resulting in death) Sequentially list conditi If any, leading to immed	ona, diate	Corona oue to Arteri	(OR AS A CONSEC TY Arter (OR AS A CONSEC	OUENCE OF	F): Seas F):	2							
resulting in death) Sequentially list condit! If any, leading to immercause. Enter UNDERLY! CAUSE (Disease or Inju	ona, diate NG ry	Corona oue to Arteri	OR AS A CONSEC TY Arter (OR AS A CONSEC OSCleros	OUENCE OF	F): Seas F):	2							
resulting in death) Sequentially list conditi If any, leading to immedicause. Enter UNDERLY! CAUSE (Disease or Injuint that initiated events resulting in death) LAS	ona, diete NG cy	OUE TO COTONA OUE TO Arteri OUE TO	(OR AS A CONSECT OF A CONSECT OF A CONSECT OF AS A CONSECT OF A CON	OUENCE OF	F): Seas F): F):							Onset and Death	
resulting in death) Sequentially list conditi If any, leading to immedicause. Enter UNDERLYI CAUSE (Disease or Injuthat initiated events resulting in death) LAST PART II. Other significations.	ona, diate NG c	Corona OUE TO Arteri OUE TO	(OR AS A CONSECT OF A CONSECT OF A CONSECT OF AS A CONSECT OF A CON	Y Di DUENCE OF SIS	F): Seas F): F):		given in	Part I.	24a. WAS AN AI PERFORM		AM	Onset and Death Break AUTOPSY FINDINGS ANLABLE PRIOR TO	
resulting in death) Sequentially list conditi If any, leading to immedicause. Enter UNDERLY! CAUSE (Disease or Injuint that initiated events resulting in death) LAS	ona, diate NG c	Corona OUE TO Arteri OUE TO	(OR AS A CONSECT OF A CONSECT OF A CONSECT OF AS A CONSECT OF A CON	Y Di DUENCE OF SIS	F): Seas F): F):		given in	Part I.		ED?	AM CO	Onset and Death Death Death Death	
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resulting in death) Sequentially list conditi if any, leading to immedicause. Enter UNDERLY! CAUSE (Disease or injuint that initiated events resulting in death) LAS* PART II. Other signification of the condit	ona, dinte NG ry r d d	OUE TO CORONA OUE TO Arteri OUE TO contributing to	(OR AS A CONSECTY AFTER (OR AS A CONSECTION AS	TH YE	Seas	lerlying cause	given in	_	PERFORM	ED?	AM CO OF	Onset and Death ERE AUTOPSY FINDINGS RILABLE PRIOR TO MPLETION OF CAUSE DEATH?	
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resulting in death) Sequentially list conditi if any, leading to immedicause. Enter UNDERLY! CAUSE (Disease or injunted in initiated events resulting in death) LAS: PART II. Other eignifica Diabetes DID TOBACCO U. 25. WAS CASE REFERRED TO EXAMINER? 1 ※ YES 2 NO 27. MANNER OF DEATH 1 ※ Natural 5 1	ona, diate NG ry True de la conditions Mellita SE CONTR Pending nvestigation	OUE TO COTONA OUE TO Arteri OUE TO CONTRIBUTE TO CA HOSPITAL: 1 Inpellent 2 28a. DATE OF	(OR AS A CONSECTY Arter (OR AS A CONSECTOR OSCIETOS (OR AS A CONSECTOR DEATH OF THE CONSECTOR USE OF DEATH 28. PLACE ER/Outpetient 3 INJURY 19/, Year)	DUENCE OF DEAL TIME	Seas Seas F): F): TH (Check of OTHER 4 Nura	lerlying cause IO UNI Inly one) Ing Home 5 (X) F BC. INJURY AT WORK? 1 YES 2	CERTAIN	8 - Oth 28d. DE	PERFORM 1 YES 2 5	IED?	AM CO OF	Onset and Death	
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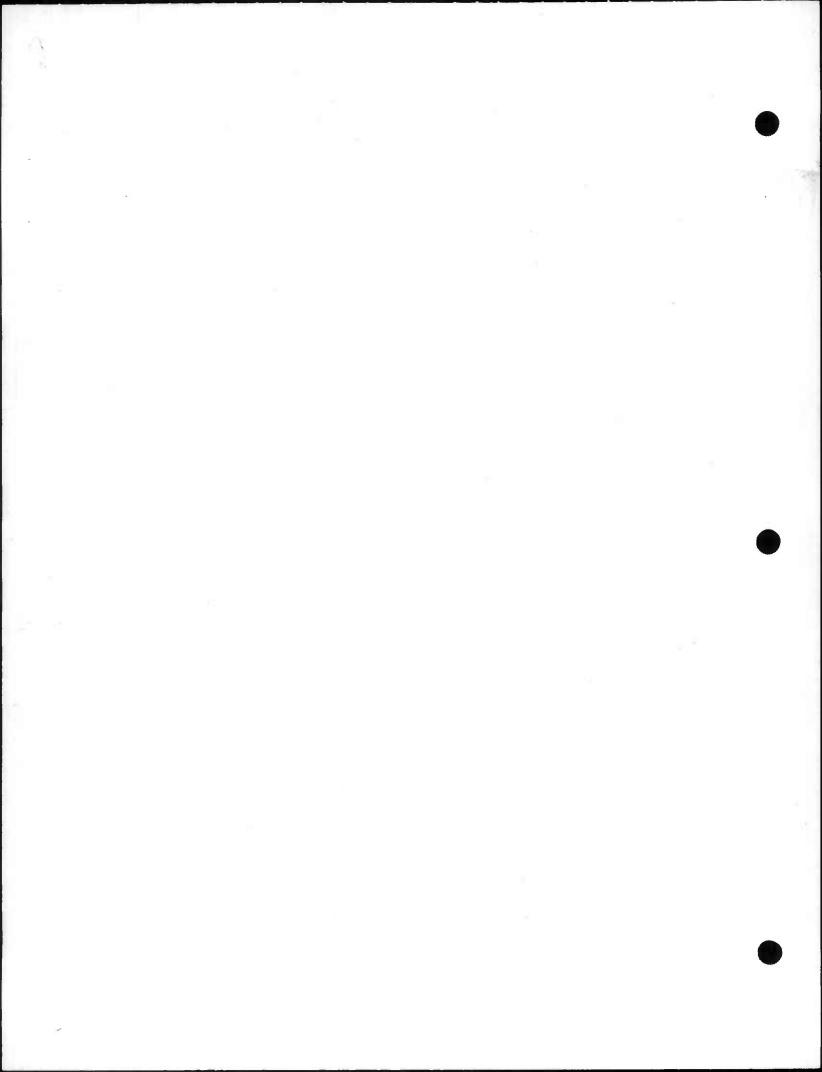
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transfer be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



j	Amended # 1. FOR STATE REGISTRAR	STATE OF MARY	LAND /	MRT DEPARTME ERTIFICA	NT OF I	Mont HEALTH AND	g o	n er L Hygien	9.	500	4.644,0	
	1. DECEDENT'S NAME (First, Middle, Last)		CE	ENTIFICA	IE OF	DEATH	_	REG. NO				
	BEVERLY 4. SOCIAL SECURITY NUMBER	MARIA		DEFAL	60		JA	Nav	ay Q	5 YEAR	TIME OF DEATH	М
	$217-32-0\frac{0312}{712}$	1 □ M 2 🔀 F 5	E (In yrs. las	YRS. IF UN	DER 1 YEAR	HOURS MIN.	(Mont	of Birth h, Day, Year) ember	36 9,19	Country)	irginia	
St.	9a. FACILITY NAME (If not institution, give s	9b. C	. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEA							_		
FUNERAL DIRECTOR	Suburban Hospital		Ве	ethes	da			Montgomery				
REC	10s. STATE 10b. COUNT	Y		10c. CITY, TOWN OR LOCATION						-10	d. INSIDE CITY	_
٥		gomery		Silve	r Spr	ing				1	LIMITS?	
RA	100. STREET AND NUMBER				10	1. ZIP CODE	006		10g. CIT	IZEN OF WHA	T COUNTRY?	_
INE	4202 Dahill Road	Tin was necessarily sugar					906			S.A.		
	1 Never Merried 2 Married	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 XN		Il yes, sp	CENDENT OF HISPA Decity Cuban, Maxic	an, Puerto	i? (Specify Yes Rican, atc.)	or No—	14. RACE — American Indian, Black, White, atc.		
BY	3 Widowed 4 Divorced	IF TES, GIVE WAN ON	DAIES	_	1 YES	S 2 NO Speci	ty:			Specify: White		
TEC	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(Gr	CEDENT'S USUAL	ne durina m	ON ost of working	16b	KIND OF BU	SINESS/INI		7722.00	_
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		Do NOT use retired	/							
OM	17. FATHER'S NAME (First, Middle, Last)		Ins	surance	Agen	18. MOTHER'S NA			ance			
BE C	Unknown					Doris I			ourname)			
TO B	19a. INFORMANT'S NAME (Type/Print)		196	. MAILING ADDR	ESS (Street	and Number or Rural			n, State, Zip	Code)		_
F	James A. DeFalco		42	202 Dah:	ill R	oad; Sil	ver S	Spring	, MD	2090	6	
	20a. METHOD OF DISPOSITION 1 Burlai 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cometery, crematory or other place)											
	4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	politan	<u>litan Crematory 1/26/95 Alexandria, Virgini</u>						irginia			
	Dan C	2	_		22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc.						Inc.	
	2 comple	Son X			500 บ	niversit	y B1	vd.W.	Sil.	Spr.,M	D 20901	
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											n
	IMMEDIATE CAUSE (Final disease or condition	Chamie	17	B structure milania au dinners						Onset and Death	h	
	resulting in death)	DUE TO (OR AS A CONSCOUENCE OF): Julianay deseluse							upe_		-	
Z	Commendation lies on distance									İ		
CERTIFICATION	Sequentially list conditions, if sny, leading to immediate	DUE TO (OR AS A CONSEQUENCE OF):								_		
5	cause. Enter UNDERLYING CAUSE (Disease or injury	C,									-	
E	that initiated events resulting in death) LAST	202 10 (011 10	A CONSEC	OLNOL OF J.								
	PART II Other classificant and its											
PHYSICIAN: MEDICAL										AVI	RE AUTOPSY FINDINGS AILABLE PRIOR TO	i
ED							-	1 TES 2	NO		MPLETION OF CAUSE DEATH?	
Σ										YES 2 NO		
X	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										_	
SI	EXAMINER?	HOSPITAL:	Ipatient 3	DOA 4 N		e 5 🗆 Residenca	6 🗆 Othe	(Specify)				_
PH	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)		26b, TIME OF INJURY	28c. INJ W0	BURY AT	28d. DESCRIBE HOW INJURY OCCURED				_	
B	2 Accident Investigation	240 BLACE OF MALE	W 44.	М	1 🗆							
ETED	3 Suicide 6 Could not be determined	26s. PLACE OF INJUF building, atc. (Sp	ecify)	ne, farm, street, fr	actory, offic	•		ATION (Street a or Town, State)	ind Number	or Rural Route	i Number,	
PLE	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the beat of my kno	wiedge, des	th occurred at the	e time, date	and place, and due	to the cau	se(s) and men	ner as stel	led.		-
COMPL		R: On the basis of examinati									d manner es stated.	
ш	299 SIGNATURE AND TITLE OF CONTINUES	. 1. 11				29c. LICENSE NUI				E SIGNED (Mo		-
TO B	Mun 7 Way	Wille My	2			294	53			MUARY		5
	30, NAME AND ADDRESS OF PERSON WHO	COMPLETED CALIFE OF D	CATAL MEMBE									-

GROVE

RO. ROCKULLE

15225

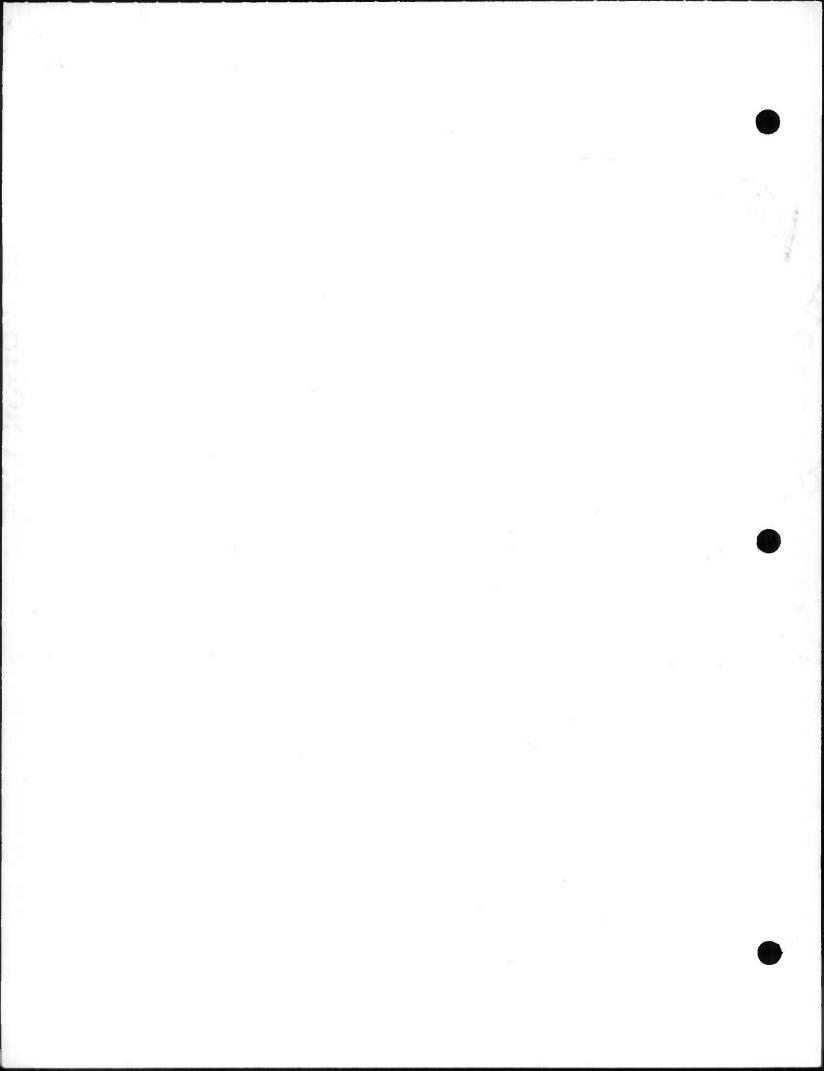
32. REGISTRAR'S SIGNATURE
Jalia Davidson Raylall

S. CHANACES

31. DATE FILED (Month, Day, Year)

JAN 2

DHMH-16 Rev 1/89



Page 6 may be retained by the hospital or attending physician, use as the funeral director, page 5 should be detached for has been signed by the attending physician and completely filled in by the Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. hours after TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law TO THE FUNEPAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. IMPORTANT: If item 28 is marked, or item 23 is

DIVISION OF VITAL RECORDS, P.O. BOX 68760

once.

notified at

must be

medical examiner

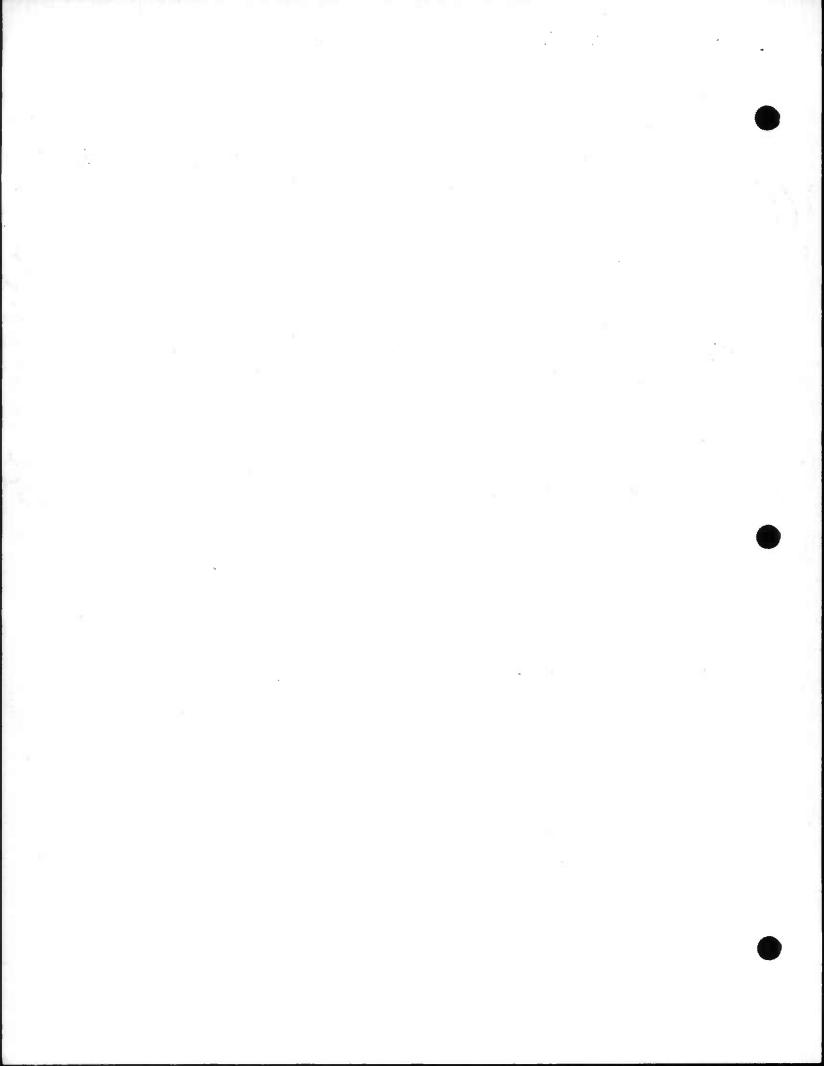
the

traumatic event,

or other

REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH January Sham Radia Long 0720 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 1 / 25 / 06 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 F 89 "MD YRS. 216-09-5899 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY RESIDENCE OF DECEDENT Salisbury 10b. COUNT 10d. INSIDE CITY LIMITS? Wicomico 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? USA 21801 419 Winder St 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No— If yes, specify Cuban, Maxican, Puarto Rican, stc.) 14. RACE — American Indian, Black, White, atc. 1 Never Merried 2 Married 1 YES 2 NO Specify: BY 3

Wildowed 4 □ Divorced Specify: white E 15. DECEDENT'S EDUCATION pecify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b, KIND OF BUSINESS/INDUSTRY (Spe COMPLET mentery/Secondary (0-12) College (1-4 or 5+) 8 Housewife Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Samuel Carey BE Sadie Baker 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 419 Winder St. Salisbury, MD Hilda Holston Hudson 20s. METHOD OF DISPOSITION
1 № Burial 2 □ Cremation 3 □ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Cemetery 1/29/95 Berlin, MD 21. SIGNATURE OF SONERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Burbage Funeral Home 108 Williams St. Berlin, MD 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart fellure. List only one cause on each lina. Approximate intervai Between **IMMEDIATE CAUSE (Final** Onset and Death diseese or condition reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? Occasion 1/acm 1 YES 2 -NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending м 1 YES 2 NO ВY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcida 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 ___ MEDICAL EXAMINER: On the basis of sxamination end/or investigation, in my opinion, death occurred at the time, data end place, end due to the cause(a) and manner as stated. 29b. SIGNATURE AND THILE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2000 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CEN Day, Year) 32. REGISTRAR'S SIGNATURE whis Deviden Ra



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician
Blocklid Kunton to midon ou fa normal of the same of t
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-train
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR				ICATE	U I		- P	REG. NO.				
- 8	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF		3. TIME OF DEATH			
- 8	Amelia V.		Estra	da				January 31,1995			YEAR 5	3:45 P M	
10	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yra	. last birthday)	IF UNDER 1	YEAR	IF UNDER 24 HRS.	7 DATE OF	PIOTH		8. BIRTI	IPLACE (State or Foreign	
- 7	217-88-1004	1 M 2 X F	91	YRS.	MONTHS	DAYS	HOURS MIN.	May 30) . 19	03	E 1 S	Salvador	
	9a. FACILITY NAME (If not institution, give at	reet and number)			9b. CITY.	TOWN C	OR LOCATION OF DE		, _,		NTY OF D		
E.	Circle Nursing Ho											5711	
K	RESIDENCE OF DECEDENT						ington Montgomery						
Ä	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWH OF	LOCAT	TION					10d. INSIDE CITY	
a	Maryland Montg	Si	lver	Spr	cing			LIMITS? 1 YES 2 X NO					
4	10s. STREET AND NUMBER		· · ·	101	. ZIP CODE			1 L YES 2 K NO 10g. CITIZEN OF WHAT COUNTRY?					
FUNERAL DIRECTOR	9802 Dilston Road				20903					10g. CITIZEN OF WHAT COUNTRY? USA			
3	11. MARITAL STATUS	EVER IN U.S.	ARMED	13. W	AS DEC	ENDENT OF HISPAN	IC OBIGINS (S	naciby Year			E — American Indian,		
	1 Never Married 2 Married	FORCES? 1 [IF YES, GIVE WA	YES 2	NO	- 11	yes, spe	ecify Cuban, Maxicar	n, Puerto Ricai	n, etc.)	- NO	Black	k, White, etc.	
B	3 🔀 Widowed 4 🗌 Divorced	# 120, GIVE 19	IN ON DATES		1 "		Salvado				Speci	Hispanic	
COMPLETED	15. DECEDENT'S EDUC		16a.	DECEDENT'S	USUAL OCC	CUPATIO	ON .		ID OF BUSI	NESS/INC	DUSTRY		
<u>.</u>	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)		(Give kind of a life. Do NOT us	vork done du se retired.)	iring mo:	st of working						
린	6	0		Hom	emake	er			wn H	ome			
ő	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAM	WE (First, Middl	e. Maiden S	umame)			
шТ	Nieves Flamenco						Irene E	scobar		,			
∞	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS ((Street a	nd Number or Rural R			State 7in	Code		
2	Blanca A. Menende	Z	ı				Road, Sil					nd 20903	
	20a, METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remo			CE AND DATE	-			DATE	20c. LOC				
	1 Burial 2 Cremation 3 Ramo	oval from State	Park	Tawn 1	per place)	ial	Park					faryland	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE /	12021	- Lawii i								neral Home	
	1165	K			11	1800	New Ham	pshire	e Ave	nue		meral nome	
	23. PART I. Enter the diseases, or c	omplications thet	ceused the	death. Do r	ot enter ti	he mod	de of dying, auch	aa cardlec	or respire	itory arr	eat,	Approximate	
- 1	shock, or heart failure. (IMMEDIATE CAUSE (Final	lst only one ceus	e on eech i	line.					-			interval Between Onset and Death	
- 1	disease or condition		Ct	100								Onset and Death	
				AS A CONSEQUENCE OF):						John John			
- 1	resulting in death)	DUE TO (OR AS A CON	SEQUENCE OF	٦٠							100	
,	resulting in death)	DUE TO (OR AS A CON	SEQUENCE OF	ን:							40.	
NOI	Sequentially list conditions,	DUE TO (Rew	SEQUENCE OF	رام							years	
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (C	Rew	eclas	رام							years	
FICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (C	Rew or as a con	eclas	7: >							years	
HILLICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (C	Rew or as a con	eclos SEQUENCE OF	7: >							years	
CEHIIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (C	R ON OR AS A CON	SEQUENCE OF	7):							years	
- 11	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (C	R ON OR AS A CON	SEQUENCE OF	7):		1 4 4		. WAS AN AN		24b.	WERE AUTOPSY FINDINGS	
- 11	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (C	R ON OR AS A CON	SEQUENCE OF	7):		couse given in F		PERFORM	ED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE	
EDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (C	R ON OR AS A CON	SEQUENCE OF	7):		1 4 4			ED?	24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
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REGISTRAR			CE	ERTIFIC	ATE O	F DEATH		REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. T									3. TIME OF DEATH		
MA	HR THI	7 EIG	EN				JAN	SARY		1995	8.30 A M
4. SOCIAL SECURITY NUMBER	ER		AGE (In yrs. les		F UNDER 1 YEA		7. DATE C	F BIRTH	21	8. BIRTH	IPLACE (State or Foreign
101-20-0432		1 🗆 M 2 📈 F	90	YRS.	ONTHS DAY	S HOURS MIN.	Jan.	Day, Year)	1905	Countr	w w York
99. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH											
Hebrew Home of Greater Washington Rockville Montgomery										rv	
RESIDENCE OF DECEDENT										-1 y	
									10d. INSIDE CITY LIMITS?		
Ma. Montgomery Rockville										1 N YES 2 NO	
10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?											HAT COUNTRY?
6121 Montrose Rd. 20852 USA											
11. MARITAL STATUS		12. WAS DECEDENT E FORCES? 1	VER IN U.S. AR	MED	13. WAS D	DECENDENT OF HISPA specify Cuber, Mexico	NIC ORIGIN?	(Specify Yes	or No-	14. RACE	— American Indian, c, White, etc.
1 Never Merried 2 3 Widowed 4 Divo		IF YES, GIVE WAR				rES 2 NO Specif		romit, with j			"White
	EDENT'S EDUC	NATION .	1 10 (00								
(Specify only	highest grade	completed)	(G	CEDENT'S US we kind of work Do NOT use n	done during	ATION most of working	16b.	KIND OF BUS	SINESS/IND	DUSTRY	
Elementary/Secondary (0	-12)	College (1-4 or 5+)									
17. FATHER'S NAME (First, M.	(eletto (a a a)		В	ookkee	eper	1					
T. PAINER S NAME (FIRST, MI	iodie, Last)					18, MOTHER'S NA	AME (First, M.	iddle, Maiden	Sumeme)		
40. 10/2004/41/20 444/20 (7	- Maria	Rothe				Etta					
19e. INFORMANT'S NAME (7)	ype/Print)					et and Number or Rural					
Cindy Rosen						air Ct. P	otoma				
20e. METHOD OF DISPOSITE 1 ☐ Burlel 2 🂢 Cremello	n 3 🗆 Remo	oval from State	20b. PLACE A cemetery, cre	no pate of a	place/_	,	DATE			City or To	
4 Donetion 5 Other			Metro	polita				5 A1	exand	dria,	Va.
21. SIGNATURE OF BUNERAL	L SERVICE LIC	D			Edwa	and address of FA	Funer	al Di	recti	ion	
· You	4/	Tusan				Rockvill					rd 20852
23. PART I Enter the di	sesses, Dr C	omplications that co	used the de	eth. Dp npt							Approximets
ghock, or he	tellure. I	let only one ceuse	on esch line								intervai Between
iMMEDIATE CAUSE (Fin disease or condition		N=T1.CO	- 61	C0 >	OTIC HEART DISCASE					Onset and Death	
resulting in desth)	7	DUE TO (OF	AS A CONSEC	L C FO	(14-	MEME	' '	21501) SE		YCHRS
	_	1000 10 (0)		oritor or j.							İ
Sequentielly list conditi		DUE TO (DR	AS A CONSEC	UENCE OF:							-
If eny, lesding to immed cause. Enter UNDERLYI				,							j !
CAUSE (Disesse or inju that initiated events	7	DUE TO (OR	AS A CONSEC	UENCE OF):							
resulting in desth) LAS	r 📗										
											+
PART II. Other significe			eth but not r	esulting in t	the underly	ring ceuse given in	Part i.	24s. WAS AN		24b.	WERE AUTOPSY FINDINGS
1	EME							1 YES 2			AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	REAMA	L INSU	FFICI	ENCY	1				(1 TYES 2 NO
DID TOBACCO U						☐ UNCERTAI	NΠ				
25. WAS CASE REFERRED TO				E OF DEATH	_		., .				
EXAMINER?		HOSPITAL:	/Outpatient 3		THER:	Iome 5 Residence	8 Other	(Specific)			
27. MANNER OF DEATH		28e. DATE OF INJ	URY	28b. TIME O	F 28c.	INJURY AT	1	RIBE HOW IN	JURY OC	CURED	
	Pending investigation	(Month, Day,	bar)	INJUR		WORK? YES 2 NO					
2 Culette	Could not be	28e. PLACE OF IN	JURY — At ho	me, farm, stre-	et, fectory, o	ffice	281. LOCA	TION (Street e	nd Number	r or Rumi R	loute Number
	determined	building, atc.	(Specify)				City or	Town, State)			
29e. CERTIFIER						-					
		CIAN: To the best of my									
			mation end/or i	nvestigstion, i	n my opinior	, death occured at the	time, date e	end place, en	d due to th	Te ceuse(e) end menner ee stated.
29b. SIGNATURE AND TITLE	OF CERTIFIER					29c. LICENSE NUI			29d. DAT	E SIGNED	(Month, Day, Yeer)
1	Teller	ray M.D				D 365	552		1	BONE	Ry 31, 1995
30. NAME AND ADDRESS OF	PERSON WHO						>				
1. TALWAR	MIS). 6121	MON	TROS	E P	-0AD. K	OCK	VILL	E 1	ND.	20852
31. DATE FILED (Month, Day,	Year)	32. REGISTRAR'S									
FEB 01	1995	Julia David	war-Kande	Щ							
		U							_		

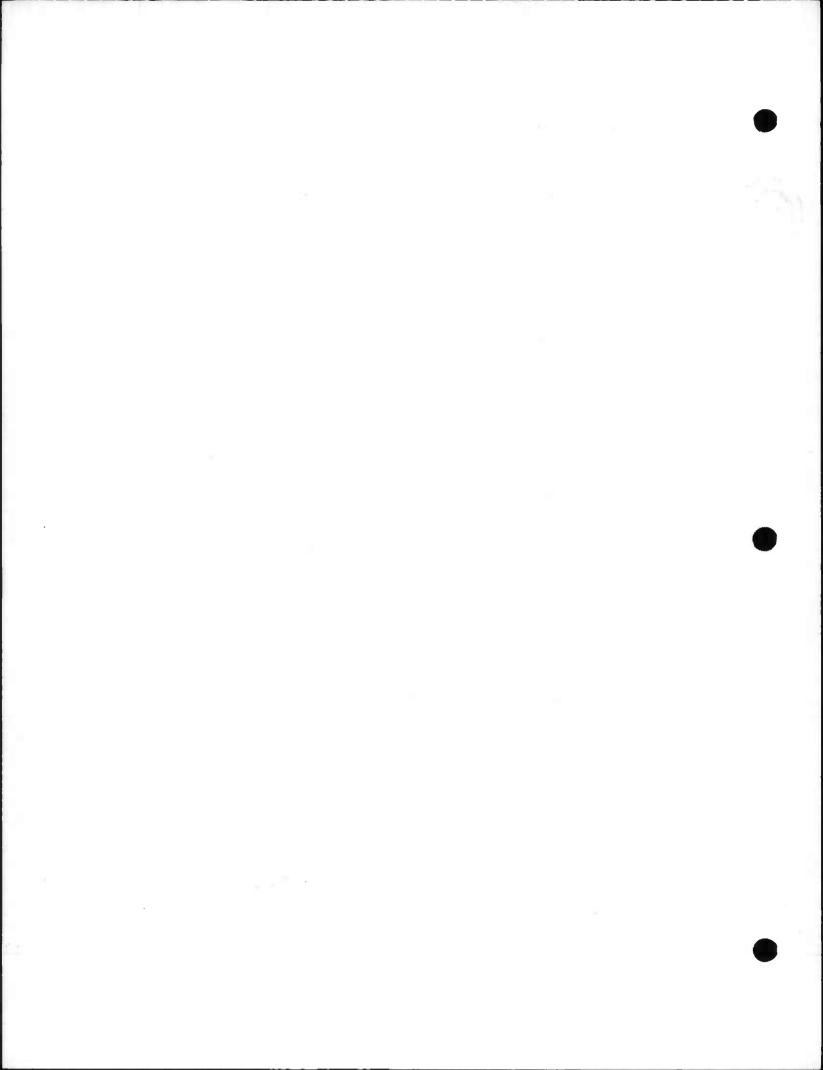
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an inclusion sterr death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO BE COMPLETED BY FUNERAL DIRECTOR

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



	FOR
1	STATE
	REGISTRAR

1 - STATE REGISTRAR		SIMIE UF I	MANTLA		ICATE				MENIAL	REG. NO			
1. DECEDENT'S NAME (First,									2. DATE C	F DEATN	AW	MEAN	3. TIME OF OEATN
LESLI					ESRI	G			JAN	UARY [™]	26,	1995	11:37A M
4. SOCIAL SECURITY NUMB		5. SEX		n yrs. lest birthdey)	IF UNDER 1 Y	-	F UNDER	24 HRS.	7. DATE O (Month,	F BIRTH Day, Year)		Countr	IPLACE (State or Foreign
052-40-265		1 (X M 2 □ F		50 YRS.						15, 1		NE	W YORK
90. FACILITY NAME (If not ins			۱۸:		96. CITY, TO						9c. COL	INTY OF D	EATN
RESIDENCE OF DEC		12 HO2P11	AL		BA	LTIM	IUKE	CI	<u> </u>				
10e. STATE	10b. COUNT	r		10c. Cl	TY, TOWN OR I	OCATIO	N						10d. INSIDE CITY LIMITS?
MARYLAND	AN	NE ARUND	EL	A	NNAPOI	LIS							1 YES 2 NO
10e. STREET AND NUMBER	NIT DI I	MEDDA OF				100	P CODE						WHAT COUNTRY?
2818 BROAI	OATEM						2140						STATES
1 Never Merried 2	Merried	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 7 NO	If y	es, specti	fy Cuber	i, Mexice	NIC ORIGIN? In, Puerlo Ri	(Specify Yes cen, etc.)	or No-	Black	— American Indian, r, White, etc.
3 Widowed 4 Divor	rced	IF TES, GIVE Y	MR OR DA	IIES	1 ''	YES 2	X) NO	Specifi	у:			Speci	WHITE
	EDENT'S EDU			16a. OECEDENT'S	S USUAL OCCL	PATION	of working	7	16b. I	KIND OF BU	SINESS/IN	DUSTRY	
Elementary/Secondary (0-	-12)	College (1-4 or 5-	·)	DENTIS	ise retired.)				_	ENTIS	יייייייייייייייייייייייייייייייייייייי		
17. FATHER'S NAME (First, Mi	Idello (a.d.)	JT		DENTIS	0.1								
CHARLES ES						1			ME (First, Mi				
19e. INFORMANT'S NAME (7)	rpe/Print)			19b. MAILIN	G ADDRESS (S	treet and						in Code)	
MICHAEL ES	SRIG												YLAND 20906
20a METHOD OF DISPOSITI		ovel from State	20b.	PLACE AND DATE	OF DISPOSITION	ON (Name	of		OATE			City or To	
4 Donetion 5 Other	(Specify)		Ju	DEAN ME	MORTAL	GAI	RDEN	IS	1/29	OL	NEY,	MAR	YLAND
21. SIGNATUTE OF UNERAL	L SERVICE LIC	ENSEE			DÃŃŹ	ANS	ADDRES KY-(SOLD	BERG	MEMOR	CIAL	CHAP	ELS, INC.
Van	de	UX	14	ne									. 20852
23. PART I. Enter the dis	seesea, or o	complications the	t caused	the death. Do	not enter th	a mode	of dyla	ng, auc	h ea cardi	ac or raapi	ratory as	rest,	Approximata
IMMEDIATE CAUSE (Fin	el	The state of		our mile.									Interval Between Onset and Death
disease or condition reaulting in death)	→	. SEA	515										4045
				CONSEQUENCE C									1
Sequentielly list condition		0		CONSEQUENCE									1 WEEL
if any, leading to immed cause. Enter UNDERLYII	NG	REA	MU	FAI	LULS								3 weeks
CAUSE (Disease or Injur that Initiated eventa				CONSEQUENCE C	•								
resulting in deeth) LAST		d. DIF	005	c LAI	CF C	CL	C	UF	114	ONA			1.5 405
PART II. Other aignifices	nt condition	s contributing to	deeth bu	it not resulting	in the unde	riying c	euse g	iven in	Part i.	24s. WAS AN		24b.	WERE AUTOPSY FINDINGS
										PERFOR			AVAILABLE PRIOR TO COMPLETION DF CAUSE
											10		OF DEATH? 1 ☐ YES 2 YNO
DID TOBACCO US	SE CONT	RIBUTE TO CA	USE O	F DEATH Y	ES NO	X	UNC	ERTAI	N 🗆				
25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	- 2	6. PLACE OF DEA	TH (Check only	one)							
1 TYES 2 NO		1 Kinpatient 2	_		4 - Nursing			idence					
27. MANNER OF DEATN 1 Natural 5 8	Pending	28e. DATE OF (Month, D		28b. Till IN	JURY	work	?	140	28d. OEŞC	RIBE HOW I	NJURY OC	CURED	
2 Accident	nvestigation	28e, PLACE O	F INJURY	- At home, term,		Office	2	NO	281 LOCAT	NON /Stonet	and Numbe	e as Premi S	loute Number,
	Could not be letermined	building,	etc. (Speci	(y)		- Other			City or	Town, Stete)	ma ryambe	r or nurer n	odia Namoei,
29e. CERTIFIER 1 CERTI	FYING PHYSI	CIAN: To the best of	my knowle	edge, death occur	red at the time	date en	d place	and due	to the coun	e(e) and mer	nor on etc	ted	
) end manner es stated.
29b. SIGNATURE AND TITLE	OF CERTIFIER	1				25	9c. LICEI	NSE NUR	MBER		29d. DA	TE SIGNEO	(Month, Day, Year)
Mil	نلا	MO		hA			17	46	104		•	1/2	1115
30. NAME AND ADDRESS OF ROBERT		O COMPLETEO CAUS	SE OF OEA	TH (ITEM 27) (Type		OUP	: E	57		BAL	70	U 2	21287
31. DATE FILED (Month, Day,)	fear)	33. REGISTRA	R'S SIGNA	TURE							J		
JAN 30	1995	Yalia da	וראפירומא	nardall									

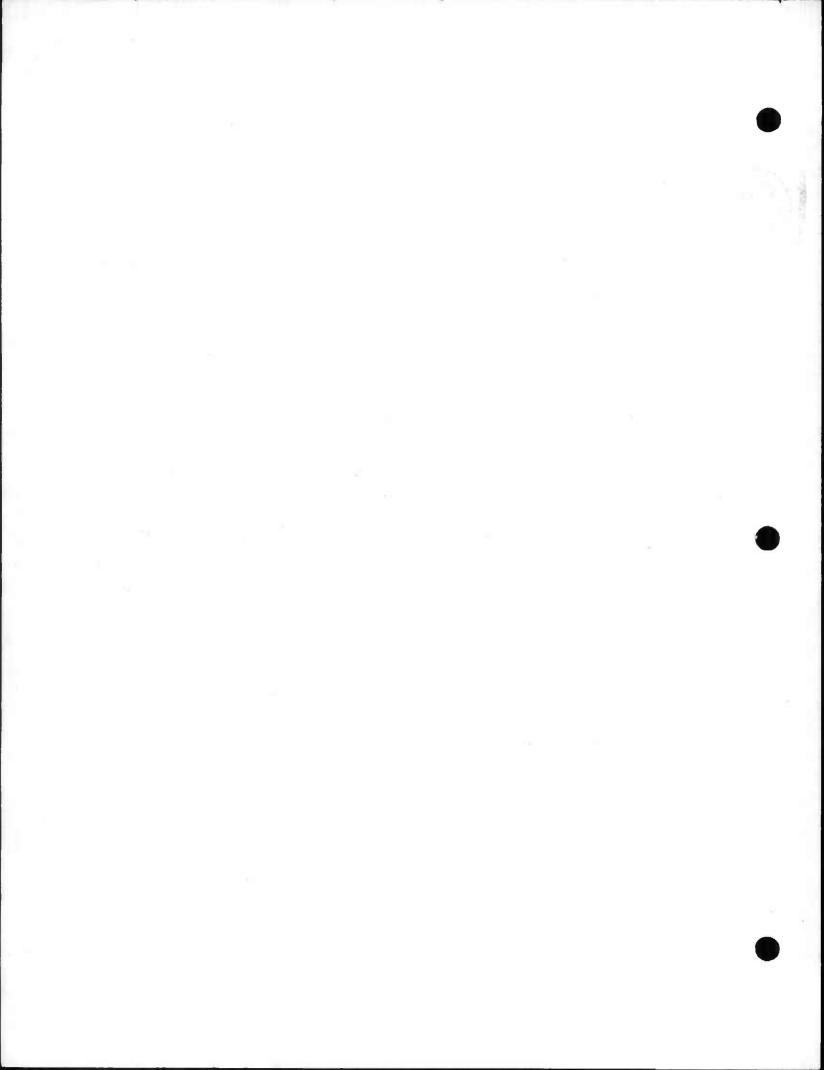
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit is be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

OHMH-16 Rev 1/89



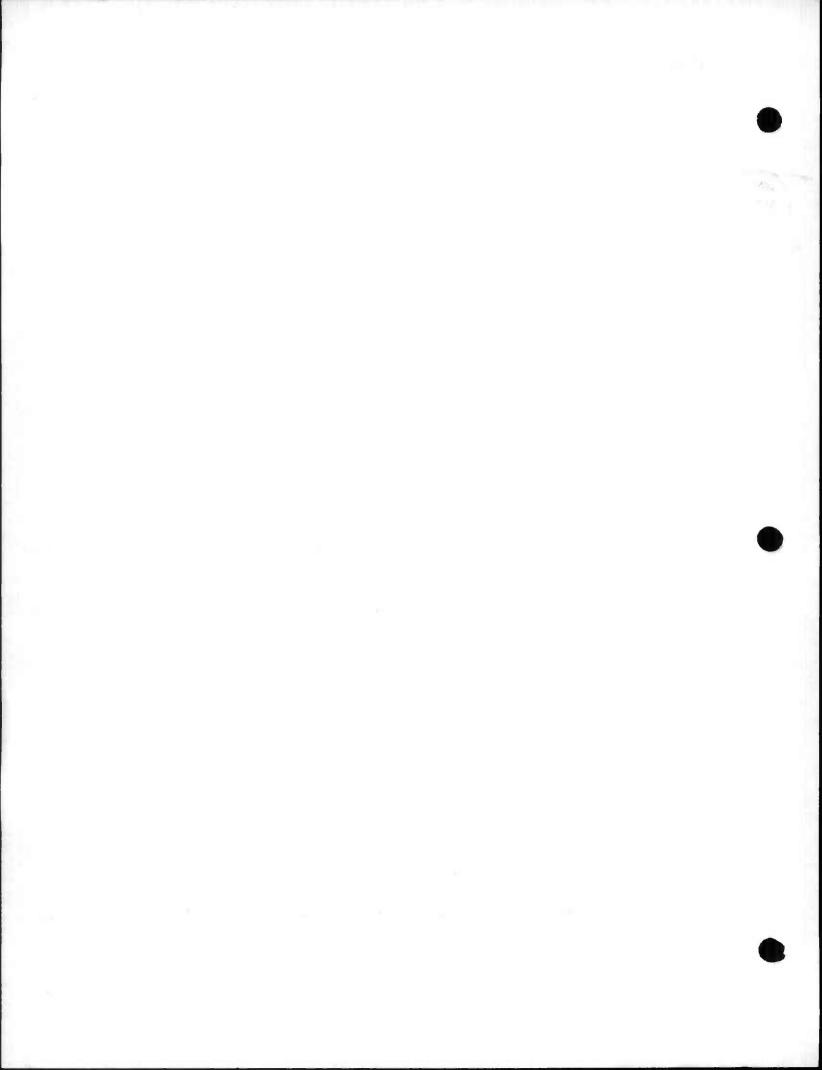
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	ospital o	thed for	aŝ
	y the h	oe detac	at one
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•	y be rel	age 5	be no
	е 6 та	ector, p	must
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	fter dea	the fur	al exa
	hours a	or rem	medic
	thin 24	stefy fille	it, the
	uted wi	comple	c ever
	be exec	ian and	aumati
	tificate	physic	ther tr
	ath cer	Ittendin	, or 0
	t the de	by the a	inju
	ires tha	signed sealth a	ws am
	aw requ	s been	3 sho
	t: The l	State De	item 2
	YSICIAL	s certifi	9d, 0r
	ING PH	After thi	mark
	ATTEND	CTOR: /	28 is
	AL OR	AL DIRE	II Hem
	HOSPIT	FUNERA withle 7	TANT
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attend	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as he filed within 72 hours after death with the State Dent, of Health and Mental Hymines prior to bridle command or semble.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

F	Amended #/ 1. STATE S REGISTRAR	2/2/95 TATE OF MARYLAN	M / D / DEPAR CERTIF	C T	OF I	Monta HEALTH AND	REG. NO	IE &	5	014645	
))	1. DECEDENT'S NAME (First, Middle, Lest) -BABY GIRL Sara	h Christi	.na		ı	EVANS	JANUARY 2	-	95 ^{KEAR}	3. TIME OF DEATH 3:45 P M	
	NT / A	SEX 6. AGE (In yr.	s. last birthday) YRS.	IF UNDER	1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		Countr	**	
	9a. FACILITY NAME (If not institution, give street a	AL.		9b. CITY	, TOWN	0R LOCATION OF D	January 26	-	Man	ryland	
OR	THE JOHNS HOPKINS	HOSPITAL		ВА	LTIN	MORE CITY	1				
FUNERAL BINECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c, CIT	Y, TOWN C	R LOCA	TION				10d. INSIDE CITY	
鯗	Maryland Montgo	mery	Bur	tons	vil	le				LIMITS?	
HAL	3659 Silver Spruce	Cirolo			10	f. ZIP CODE		10g. CIT		WHAT COUNTRY?	
S		WAS DECEDENT EVER IN U.S	ARMED	13. 1	WAS DE	20866	NIC ORIGIN? (Specify Ye	or No.	USA	- American Indian,	
BY	1 Never Merried 2 Merried	FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	X NO		If yes, sp	ecify Cuben, Mexica 2 X NO Specif	in, Puerlo Rican, atc.)	or No-	Black	White with White	
COMPLETED	15. DECEDENT'S EOUCATIO (Specify only highest grade comp Elementary/Secondary (0-12) Co	IN 16s (leted) 16s (lege (1-4 or 5 +)	Give kind of life. Do NOT un	work done	CCUPATI during mo	ON ost of working	16b. KIND OF BU	SINESS/INC	USTRY		
SON	17. FATHER'S NAME (First, Middle, Lest)						ME (First, Middle, Meiden	,			
BE	Alan James Evans 190. INFORMANT'S NAME (Typo/Print)						en Patric				
2	Kathleen K. Evans						Route Number, City or Tow rcle Burto			MD 20866	
	20c. METHOD OF DISPOSITION 1) Burlist 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cometery, cremetory, or other place) 20c. LOCATION — City or Town, State										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gate of Heaven Cemetery 1/30/95 Silver Spring, Mar 22. NAME AND ADDRESS OF FACILITY										
	· Christophen	Maskbu	~_	5	Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil.Spr.mMD 209 anter the mode of dylng, such as cardiac or respiratory arrest. Approximately						
	23. PART I. Entar the diseases, or comp ahock, or heart failure. List of IMMEDIATE CAUSE (Final	elications that caused the only one cause on each	ilna.	not anter	tha mo	de of dying, suc	h as cardiac or resp	iratory ari	est,	Approximate Interval Between Onset and Death	
	diamen or an attalan	externe DUE TO (OR AS A CO)	ne	ma	hu	ity				16 min	
_			G mi			10				11.	
CATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A COM	SEQUENCE O	F):		11 /	quancy	Vi	,	6 KG	
FICA	CAUSE (Disease or Injury	DUE TO (OR AS A CON	cle ta		45/	Maria	cousid	ereo		28 wks	
CERTII	that initiated events resulting in death) LAST	to be le		,-	1 1						
	PART II. Other aignificant conditions con	ntributing to death but n	ot resulting	in the un	derlyin	g cause given in	Part I. 24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
PHYSICIAN: MEDICAL							1 JYES 2	□ NO		COMPLETION OF CAUSE OF DEATH?	
×	DID TOBACCO USE CONTRIBU	JTE TO CAUSE OF D	FATH YE	SIL	אס וי	UNCERTAIN				1 YES 2 NHO	
CIAN	25. WAS CASE REFERRED TO MEDICAL	26. P	LACE OF DEA	TH (Check o	only one)	OTTERNAL	· Li				
YSI		SPITAL: Impatient 2 - ER/Outpetien		- V	lng Hom	e 5 🗆 Residence	8 Other (Specify)				
	1 Natural 5 Pending	26e. DATE OF INJURY (Month, Day, Year)	28b, TIM	E OF URY M		URY AT PRK? YES 2 NO	28d. DEŞCRIBE HOW I	NJURY OCC	VRED		
ED BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY — A building, etc. (Specify)	t home, farm, s	street, fecto			281. LOCATION (Street		or Rural Ri	oute Number,	
ETE	4 Homicide determined	, can (speakly)					City or Town, State)				
COMPLET	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On									end menner ee stated.	
шШ	29b. SIGNATURE AND LITLE OF CERTIFIER					29c. LICENSE NUM				(Month, Day, Year)	
TO B	maith last ke	258:4V1	L.D.			D40	175	> 1	30	0/95	

Ross ITER

FFB 02 1995

DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 mould be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

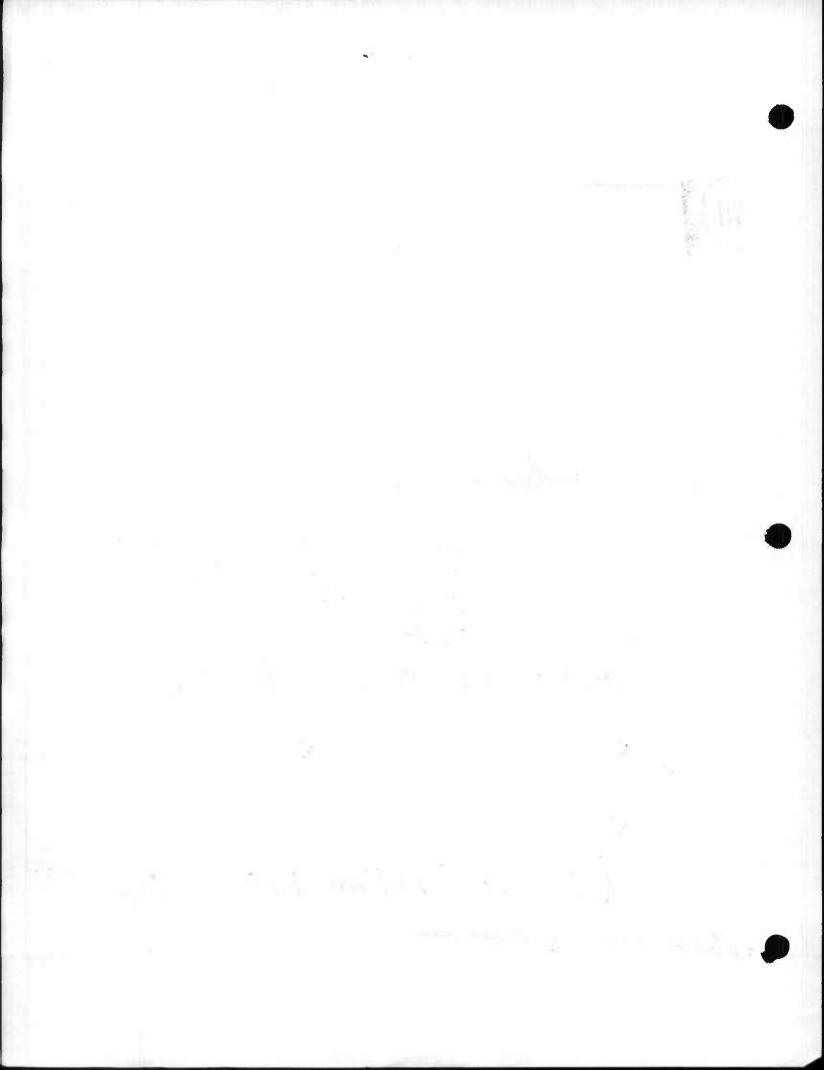
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

JAN 4U 35

						. "						15	04646	
	1 - FOR STATE REGISTRAR		STATE OF N	MARYLAN	D / DEPAR	RTMEN'	T OF H	EALTH DEAT	AND I	MENTAL HYGIE	_			
7	1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE OF DEATH	W. 1. 1. 1.		3. TIME OF DEATH	
	Roy E. F	lowers	S							January 1	2, 19	95 ^{SEAR}	2005 M	
	4. SOCIAL SECURITY NUMB	ER :	S. SEX	6. AGE (In yr	s. lest birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7 DATE OF BURTH		B. BIRTI	HPLACE (State or Foreign	
	221-07-4364	4	1 💢 M 2 🗆 F	7	7 YRS.	MONTHS	DAYS	HOURS	MIN.	Sept. 12,	1917	Del	aware	
	9a. FACILITY NAME (If not ins	stitution, give stree	et and number)			9h CITY	TOWAL C	OR LOCATIO	N OF DE		_	UNTY OF C		
1	Pear Tree		(AT H	OME)				rtow						
а	ESIDENCE OF DEC		(AL II	OFIE /		CII	este	I LOWI	.1		Ų	ieen	Annes	
떏	Da. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION					10d, INSIDE CITY	
₩.	Maryland	Oueen	Annes			Che	ster	town					LIMITS? Y	
4	STREET AND NUMBER	quota				OIIC		ZIP CODE			40 00		1 YES 2 1 NO	
E.	Transaction Accesses	Door Tr	ee Point	-				21620					WHAT COUNTRY?	
y I												U.S.		
FUNERAL	11. MARITAL STATUS 1 Never Married 2	Married	2. WAS DECEDEN FORCES? 1	X YES 2	NO NO					HC ORIGIN? (Specify Yor, Puerto Rican, etc.)	es or No-	14. RACI	E — American Indian, k, White, atc.	
B	3 Widowed 4 Divor		IF YES, GIVE W	WAR OR DATES	3		1 TYES	2 1 NO	Specify	y:		Spec	sffy:	
			World V					_					White	
Ш	(Specify only	EDENT'S EDUCA' highest grade co		164	(Give kind of life, Do NOT u.	Work done	CCUPATIO during mo:)N st of workin	g	16b, KIND OF B	JSINESS/IN	DUSTRY		
4	Elementary/Secondary (0-	-12)	College (1-4 or 5			100								
COMPLETED	12 yrs		2 yrs		Masona	ry E	xper	t		Build	ing (Contr	ract	
8	17. FATHER'S NAME (First, Mi									ME (First, Middle, Malde		-		
BE	Milton Roy		Anna					. Harring	ton					
	19a. INFORMANT'S NAME (Ty		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or						0					
2	Sarah Parde	Pear Tree Point, Cheste							tertown, Maryland 21620					
	204 METHOD OF DISPOSITION	ON		20b. PL/	20b. PLACEAND DATE OF DISPOSITION (Name of OATE 20c. LO									
	1 X Buriel 2 Cremation 4 Donation 5 Dotter		al Irom State	tata sematan-prometon-manthas placel									Maryland	
	21. SIGNATURE OF FUNERAL		ote 11	100									THEYTCHE	
		01	Man	XX	Fellows - Well:									
	William	L. King	g, Jr.	-	_//						stertown, Maryland 21620			
	23. PART i. Enter the die	seasea, or cor	npiicationa tha	t caused the	death. Do	not anter	the mo	da of dyi	ng, auc	h aa cardiac or res	piratory a	rrest,	Approximata	
- 1	immediate cause (Fine		st only one cau	ise on each	line.							,	Interval Between Onset and Death	
- 1	disease or condition			1	8 /	2 ./	1.1	-	-	:00	100	Mili		
- 1	resulting in death)	a.,	DUE TO	IOR AS A CO	NSECHIENCE O	- / V	10			13100	Va	4		
_			552.15	7	1	0	_	AI	001	la Mess	. 1 .	M		
5	Sequentially list condition		DHE TO	IOR AS A CO	NSEQUENCE O	uce	6	1	10	7/1000		-		
٦	if any, leading to immed cause. Enter UNDERLY!		502.10	(OII AS & CO.	1 TO	r).	0	212	6					
3	CAUSE (Disease or injur		DUE TO	(OD 45 4 66)	NSEQUENCE O			//						
CERTIFICATION	that initiated events resulting in death) LAST		DOE TO	T LA	T-	r):								
F		d.		UN	T									
- 1	PART II. Other aignificar	nt conditions	contributing to	death but n	ot resulting	in the ur	nderlying	cause o	iven in/	Part i. 24s. WAS A	VALITOPSY	245	. WERE AUTOPSY FINDINGS	
5	50	-191	0 17	11000	11	77 7	1/18	1/4	1		RMED?	1	AMILABLE PRIOR TO	
5	- 26	2000	- 1-12	Jun	vay !	000	W	410	NV	1 TYES	2 NO		OF DEATH?	
Ĕ											1 4		1 YES 2 NO	
ž														
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO EXAMINER?							ACE OF OE	ATH (Ch	eck only one)				
7	1 TYES 2 TYPO		OSPITAL:	ER/Outpatier	H 3 DOA	4 Nun		5 W Res	sidence	6 Other (Specify)				
	27. MANNER OF GEATH		28a. DATE OF		28b. TIM	E OF	28c. INJU	JRY AT		28d. DESCRIBE HOW	INJURY OC	CURED		
	1-	Pending restigation	(Month, D.	ay, Year)	IN.	URY	1 Y	RK? 'ES 2	NO					
5	2 Control		28a. PLACE O	F INJURY - A	It home, farm,	street, fact	ory, office			261. LOCATION (Street	and Numbe	v or Rumi I	South Number	
3		Could not be letermined	building,	etc. (Specify)			,			City or Town, State		w critical f	nose rumper,	
ų I	29a, CERTIFIER						-							
1	(Check only									to the cause(e) and me				
COMPLEIE	one) 2 MEDIC	CAL EXAMINER:	On the besie of a	camination and	d/or investigation	in, in my o	pinion, de	eath occurr	d at the	time, data and place, a	nd due to t	he cause(s	a) and manner as stated.	
	296. SIGNATURE AND TITUE	OF CENTIFIER	1//	1	1		2.0	29e. LICE	NSE NUN	IBER 2	29d. DA	TE SIGNED	(Month, Day, Year)	
M M	H	TALL	16	1110	110	48	m)	7) 1	17801	D 3	17/	L. 1990	
o II	N/	MUSIC	x = x = x	M	100	LIL	11	/	//	0001	1 /	14	m 1610	

guna: Ballasan igothere



DIRECTOR

FUNERAL

BY

COMPLETED

BE (

2

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

2

Item

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TO THE HOSPITAL DR ATT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Item 2

a	S	

Pages 1, 2, 3 should

ITEM: 9a, PEF ITEMS: 23 PAI	F.H. RT F. 27	7. 28a-f. Pl	ER MEO) FIL	.м G-7	20 2/	13/9	5 t.t				Q	5	04647
FOR STATE REGISTRAR	., .,	STATE OF M		ND /	DEPAR	TMENT	OF I				HYGIEN REG. NO.		J	04041
1. DECEDENT'S NAME (First	Middle, Last)									2. DATE OF	DEATH		YEAR	3. TIME OF DEATH
GLENN		OWEN			FUNE	CHOU	SEF	₹		JAN	31	19		12:23 PM
4. SOCIAL SECURITY NUME	ER	5. SEX	6. AGE (tn	yrs. last	birthday)	IF UNDER		IF UNDER		7. DATE OF (Month, L	lone Manuel		8. BIRTH Count	HPLACE (State or Foreign
220-62-5193		1 🔀 M 2 🗆 F	40		YRS.	MONTHS	DAYS	HOURS	MIN.		16, 1	954		hington DC
98. FACILITY NAME (If not in BILLINGSLEY BILLINGS RESIDENCE OF DEC	LER F	RD.						or Location	ON OF D	EATH			NTY OF D	ES COUNTY
10a. STATE	10b. COUNTY	1			10c. CITY	r, TOWN O	R LOCA	TION						10d. INSIDE CITY
Maryland	Prince	e George'	S		1 Accoleoole						LIMITS?			
10e. STREET AND NUMBER					101. ZIP CODE					10g. CITIZI			WHAT COUNTRY?	
16109 Newasl	na Lan	e			20607				USA					
11. MARITAL STATUS 1 Never Married 2 3 Wildowed 4 Divo		12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES	S 2 NO If yes, specify Cuban, Maxic					can, Puerto Rican, etc.) Bis				E — American Indian, k, White, stc. //y: 1 te	
	EDENT'S EOU		1		CEDENT'S			ON ost of working	na	16b. K	ND OF BUS	INESS/IN	DUSTRY	
Elementary/Secondary (0	-12)	College (1-4 or 5 +		life.	Do NOT us	e retired.)								
12				Ro	oofer						Const	ruct:	ion	
17. FATHER'S NAME (First, M	iddle, Last)							18. MOTI	HER'S NA	ME (First, Mid	dle, Maiden	Surname)		
Galen Jesti	ıs Fun	khouser						H€	elen	Mae V	laugh			
19e. INFORMANT'S NAME (7	ype/Print)			19b	. MAILING	ADORESS	(Street	and Number	or Rural	Route Number,	City or Town	n, State, Zij	p Code)	
Galen J. Fur	nkhouse	er		10	5109	Newa	isha	Lane	e, A	ccokee	ek, M	D 20	607	
20a. METHOD OF OISPOSIT		oval from State			ND OATE O			ame of		OATE	20c. LO	CATION —	City or To	own, State

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **IMMEDIATE CAUSE (Final** disease or condition reaulting in death)

4 ☐ Donation 5 ☐ Other (Specify)

4 Donation 5 Donath Service Ucensis

. ALCOHOL AND DESIPRAMINE INTOXICATION

Trinity Memorial Gardens

22. NAME AND ADDRESS OF FACILITY
Huntt Funeral Home, Inc.

P. O. Box 156, Waldorf, MD 20604-0156

DUE TO (OR AS A CONSEQUENCE OF)

Car

Matthews

Μ.

Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in dasth) LAST

1 Natural

2 Accident

3XX Suicide

4 Homicide

DUE TO (OR AS A CONSEQUENCE OF):

OUE TO (OR AS A CONSEQUENCE OF):

PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

24e. WAS AN AUTOPSY 1 YES 2 NO

Waldorf, MD

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

Approximata

interval Betwe

Onset and Death

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: g Home 5 - Residence XXOther (Specify)

FOUND: 1-31-95

XXYES 2 NO 27. MANNER OF DEATH

Pending Investigation

8 Could not be

1 | Inpetient 2 | ER/Outpetient 3 | DOA 28a. DATE OF INJURY

28b. TIME OF 28c. INJURY AT WORK? II:25 AM 1 YES 2 XXNO

28d. DESCRIBE HOW INJURY OCCURED SUBJECT TOOK DRUGS

28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) IN AUTO

281. LOCATION (Street and Number or Rural Route Number, City or Town, State) S PATRICKS DRIVE

SCENE

29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mariner as stated,

2 X MEDICAL EXAMINER: On the stigation, in my opinion, death occured at the time, date and pieca, and due to the cause(e) and manner se stated.

OF DEATH (STEM 27) (Type, Print)

O.C.M.E

29c. LICENSE NUMBER

29d. OATE SIGNED (Month, Day, Year) FEB 01, 1995

OBORE

111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year)

32.

BALTIMORE, MARYLAND 21215-0 has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1.23 shows any injury, or other traumatic event, the medical examiner must be notified at once. Page 6 may be retained by the hospital or hours after death. DIVISION OF VITAL RECORDS, P.O. BOX 68760 r this certificate hin with the State D HOSPITAL DR ATTENDING PHYSICIAN: DIRECTOR: After this cer hours after death with the

DHMH-18 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

No. 19a, 1/23/95	, E.T, W	orceste	er Co	0.					0	0 4 0 4 0
1 - FOR STATE REGISTRAR	STATE OF MAR			TMENT OF H		MENTAL	HYGIENI REG. NO.	E		
1. DECEDENT'S NAME (First, Middle, Last)							OF DEATH			3. TIME OF DEATH
Herbert Lenzy 4. SOCIAL SECURITY NUMBER	Faulconer	ACE // land	Line de la		T	1 1	1	9	YEAR 95	
579-20-9868	1)ズ M 2 ☐ F	AGE (In yrs. last		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Month 12	14/25		8. BIRTH Countr	PLACE (State or Foreign MD
9e. FACILITY NAME (If not institution, give					OR LOCATION OF OR	EATH		9c. COU	NTY OF D	EATH
Atlantic Gener	al Hospital			Berl	in			Wo	orces	ster
MD 106. COUNT	Worcester		10c. CITY	, town or locat Ber						10d. INSIDE CITY LIMITS? 1 YES 2 NO
10e. STREET AND NUMBER			•	101	. ZIP CODE			10g. CITI	ZEN OF W	HAT COUNTRY?
6220 South Po	oint RD				21811				US	A
11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 23 IF YES, GLYG WAR	YES 2 NO		If yee, sp	ENDENT OF HISPAR ecify Cuben, Mexice 2 NO Specifi	n, Puerto R	? (Specify Yes lican, etc.)	or No—	14. RACE Black	- American Indian, i, White, etc. by: White
15. DECEDENT'S ED (Specify only highest grad	UCATION le completed)	16a. DEC	EDENT'S U	USUAL OCCUPATION done during more retired.)	ON est of working	16b.	KIND OF BUS	INESS/IND	USTRY	
Elementery/Secondary (0-12)	College (1-4 or 5+)	me. t		iceman			Law	Enfo	rcem	ent
17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S NA	ME (First, M	fiddle, Maiden S	Surneme)		
Thomas J. Fa	ulconer						Smith			
Donna Jane F	aulconer				ond Number or Rural I					
20a. METHOD OF DISPOSITION				F DISPOSITION (Na		OATE		ATION —	1811 City or To	wn, State
1 Buriel 2 Cremetion 3 Rer 4 Donetion 5 Other (Specify)	noval from State	cemetery, crem	atory or oth	her place)						
		Cape	Heni	open Cr	rematory	1/20	/95 F	-ranl	cford	d. DF
21. SIGNATURE OF PUNERAL BERVICE L	Buty	<u> </u>	Henli	22. NAME AI	rematory ND ADDRESS OF FA Williams	CILITY	Burba	ge F	unei	d. DE ral Home 1811
23. PART I. Enter tire diseases, or	complications that ce	usad the dae		108	Williams	St.	Burba Berlin	ge F	unei) 2	ral Home 1811
23, PART I. Enter the disease, or shock, or heart fallura IMMEDIATE CAUSE (Final	complications that ce	usad the dae		108	Williams	St.	Burba Berlin	ge F	unei) 2	ral Home 1811
23. PART I. Enter the diseases, or shock, or heart fallura	complications that ce	usad the dae		108	Williams	St.	Burba Berlin	ge F	unei) 2	ral Home 1811 Approximate Interval Between
23. PART I. Enter the diseases, or shock, or heart failura IMMEDIATE CAUSE (Final disease or condition	complications that ce	usad the dae		108	Williams	St.	Burba Berlin	ge F	unei) 2	ral Home 1811 Approximate Interval Between
23, PART I, Enter the disease, or shock, or heart failura IMMEDIATE CAUSE (Final disease or condition resulting in daeth) Sequentially list conditions,	complications that ce	usad the dae		108	Williams	St.	Burba Berlin	ge F	unei) 2	ral Home 1811 Approximate Interval Between
23. PART I. Enter the disease, or shock, or heart failura IMMEDIATE CAUSE (Final disease or condition resulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	complications that ce	usad the dae		108	Williams	St.	Burba Berlin	ge F	unei) 2	ral Home 1811 Approximate Interval Between
23, PART I. Enter the disease, or shock, or heart failura immediate cause or condition resulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	complications that ce List only one ceuse of DUE TO (OR b. Districtions)	usad the dae	lutine Do not lutine of the lu	108 ot anter the mo	Williams	St.	Burba Berlin	ge F	unei) 2	ral Home 1811 Approximate Interval Between
23, PART I, Enter the disease, or shock, or heart failura IMMEDIATE CAUSE (Final disease or condition resulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	complications that ce List only one ceuse of DUE TO (OR b. Districtions)	usad the dae on aech lina. M. CASA CONSEON	lutine Do not lutine of the lu	108 ot anter the mo	Williams	St.	Burba Berlin	ge F	unei) 2	ral Home 1811 Approximate Interval Between
23, PART I. Enter the disease, or shock, or heart failura immediate cause or condition resulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daeth) LAST	complications that ce List only one ceuse of DUE TO (OR b. Distriction of the total	AS A CONSECU	SENCE OF	108 ot anter the mo	Williams de of dying, such	St. h as cerd	Burba Berlin	ge F	uner D 2	Tal Home 1811 Approximate interval Between Onset and Death
23, PART I. Enter the disease, or shock, or heart failura immediate cause or condition resulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	complications that ce List only one ceuse of DUE TO (OR b. Distriction of the total	AS A CONSECU	SENCE OF	108 ot anter the mo	Williams de of dying, such	St. h as cerd	Burba Berlin lac or respir	ge F , MI atory err	uner D 2	ral Home 1811 Approximate Interval Between
23, PART I. Enter the disease, or shock, or heart failura immediate cause or condition resulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daeth) LAST	complications that ce List only one ceuse of DUE TO (OR b. Distriction of the total	AS A CONSECU	SENCE OF	108 ot anter the mo	Williams de of dying, such	St. h as cerd	Burba Berlin lac or respir	ge F , MI atory err	uner D 2	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset
23, PART I. Enter the disease, or shock, or heart failura immediate cause or condition resulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daeth) LAST	a. Durant To your to your your your your your your your you	AS A CONSECU	Mence of service of sulting in	108 ot anter the mo	Williams da of dylng, such	St. h as cerd	Burba Berlin lac or respir	ge F , MI atory err	uner D 2	Approximate Interval Between Onset and Death Onset and Death Were Autopsy Findings AMAILABLE PRIOR TO COMPLETION DF CAUSE
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23. PART I. Enter the diseases, or shock, or heart failura immediate CAUSE (Final disease or condition resulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in daath) LAST PART II. Other significant conditions DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation Investigatio	complications that ce List only ona ceuse a. DWM DUE TO (OR b. DWE TO (OR c. DWE TO (OR d. RIBUTE TO CAUS HOSPITAL: 1 Inpetient 2 ER 28e. PLACE OF INJ. (Month, Day, M. 28e. PLACE OF IN, building, etc.	AS A CONSECULAR AS A CONSECULA	JENCE OF JENCE OF JENCE OF DEATH OF DOA 26b. TIME INJURIES.	22. NAME AI 108 ot anter the mo the underlying NO [NO [NO Check only one) OTHER: 4 Nursing Hom S. OF [M.	Williams Ida of dylng, such Grause given in UNCERTAIN S S Reeldence URY AT RK? NO	Part I. 6 Other 28d. DESd.	Burba Berlin 24a. WAS AN / PERFORI 1 YES 2 (Specify) CRIBE HOW IN	AUTOPSY MED? WED? JURY OCCURATION	cuner 2 24b.	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset
23. PART I. Enter the diseases, or shock, or heart failura immediate CAUSE (Final disease or condition resulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in daath) LAST PART II. Other significant conditions DID TOBACCO USE CONTEXT IN TOWN TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 1990. CERTIFIER (Check only 120 CERT	complications that ce List only ona ceuse a. DWTW DUE TO (OR b. DWE TO (OR c. DWE TO (OR d. DWE TO (LUSAND THE OFFICE OF DEAT 26. PLACE (Specify) As how ledge, death (knowledge, death line) and the death line of the deat	JENCE OF JENCE OF JENCE OF DEATH DOA 26b. TIME INJURIES OF JENCE O	22. NAME AI 108 ot anter the mo the underlying NO [H (Check only one) OTHER: 4 Nursing Hom COF 26c. INJ JIPY M 10 10 10 10 10 10 10 10 10 10 10 10 10	Williams da of dylng, such Grause given in UNCERTAIN S Reeldence URY AT FES 2 □ NO end place, end due	Part I. 6 Other 26d. DESc. to the count	Burba Berlin ac or respir 24a. WAS AN / PERFORI 1 YES 2 (Specify) CRIBE HOW IN ATION (Street as or Town, State)	AUTOPSY MED? AUTOPSY MED? AND NO MED?	cuner 2 eat, 24b.	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death

OF OEATH (ITEM 27) (Type, Print)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-fapsit perribe filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

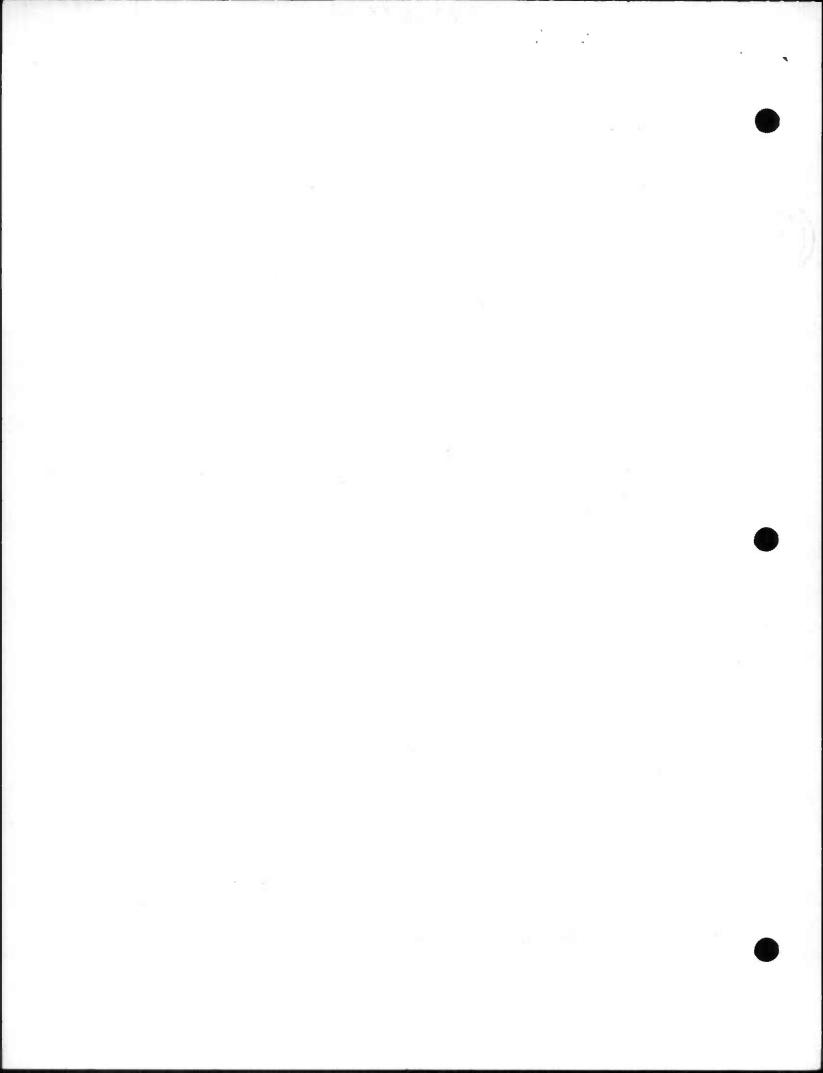
5

JAN 20 1995

Dr. Lilah Gonzalez Atlantic General Hospital PO Box 8 Berlin, MD

28798

21811



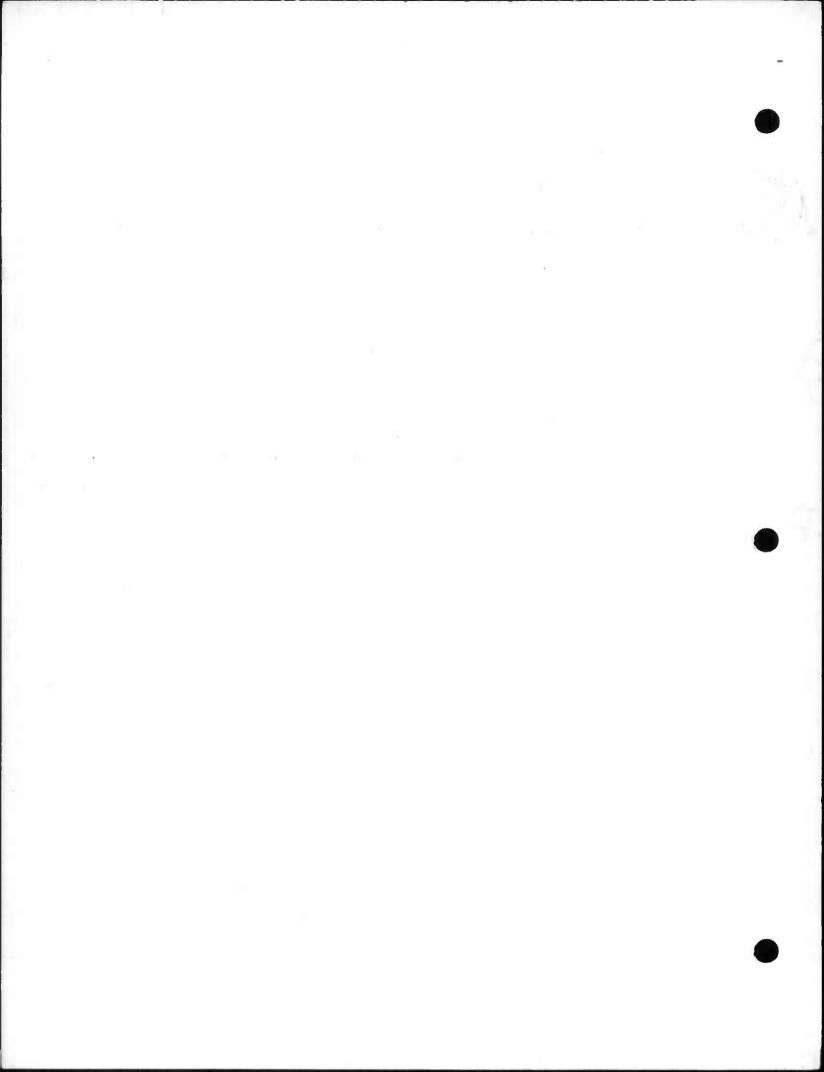
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing after fleath. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT. If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

MONTH DAY MEAN	
MONTH DAY MEAN	TIME OF DEATH
ROBERT JAMES FOX FEB 04 95 1	:29 P.M
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLA	ACE (State or Foreign
21.5-98-0526 1 1 1 M 2 F 24 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) Country) Mass	achusett
9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEAT	
270 HILLSMERE DRIVE ANNAPOLIS ANNE ARU	INDEL
RESIDENCE OF DECEDENT	
1.	Id. INSIDE CITY
	☐ YES 🏋 NO
10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT	T COUNTRY?
270 Hillsmere Drive 21403 USA	
1 Never Married 2 Merried Black, W Specify: Specify: Specify: Mexican, etc.) 1 YES 2 NO It yes, apecify Cuben, Mexican, etc.) 1 YES 2 NO Specify: Specify:	American Indian, /hite, etc. White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working	WHILE
Elementary/Secondary (0-12) College (1-4 or 5 +)	
12 4 Branch General Manager Carpet Clean	ing
17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname)	
Richard Fox Diane Lorber	
19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Richard and Diane Fox 6325 Spinnaker Lane, Alpharetta, G	A 30202
20e. METNOD OF DISPOSITION 1 Cameton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) 20c. LOCATION — City or Town,	State M.D.
4 Donation 5 Other (Specify) Lakemont Memorial Gardens 2-9-95 David	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Barranco and Sons Funeral H	
ARRANCO TO 495 Ritchie Hwy Severna Par	k. MD
23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest,	Approximete
ahock, or heert fallure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) CARDIAC ARRHYTHMIA	interval Batwean Onset and Death
Sequentielly list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	
0.	
PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 24a, WAS AN AUTOPSY 24b, WE	FRE AUTOPSY FINDINGS
PERFORMED? AMA	ERE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE
PERFORMED? AMA CO 1 YES 2 NO OF	AILABLE PRIOR TO OMPLETION OF CAUSE DEATH?
PERFORMED? 1 YES 2 NO 1 T	AILABLE PRIOR TO EMPLETION OF CAUSE
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 22. NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)	AILABLE PRIOR TO OMPLETION OF CAUSE DEATH?
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 2 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:	AILABLE PRIOR TO OMPLETION OF CAUSE DEATH?
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 2 S. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 N SES 2 NO 25. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpattent 3 DOA 4 Nursing Home 5 Other (Specify) 27. MANNER OF DEATH 280. DATE OF INJURY 280. TIME OF 280. INJURY AT 280. DESCRIBE HOW INJURY OCCURED	AILABLE PRIOR TO OMPLETION OF CAUSE DEATH?
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 2 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpetient 2 ER/Outpetlent 3 DOA 4 Nursing Home ST Residence 8 Other (Specify) 27. MANNER OF DEATH 1 Netural 5 Pending Pending Performed	AILABLE PRIOR TO OMPLETION OF CAUSE DEATH?
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH YES NO UNCERTAIN 27. MANNER OF DEATH 1 Natural S Pending Investigation 280. DATE OF INJURY 280. DATE OF INJURY Month, Day, Vear) 280. DATE OF INJURY Month, Day, Vear) 280. PLACE OF INJURY At home, term, street, factory, office 281. LOCATION (Street and Number or Burn) Bouling	ALLABLE PRIOR TO MAPPLETION OF CAUSE DEATH? YES 2 NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 2 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO OTHER: 1 OTHER: 1 Natural S Pending Investigation Pending In	ALLABLE PRIOR TO MAPPLETION OF CAUSE DEATH? YES 2 NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 1 I I I I I I I I I	ALLABLE PRIOR TO DEATH? YES 2 NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Impetient 2 ER/Outpettent 3 DOA A Nursing Home 1/2 Residence 5 Other (Specify) 27. MANNER OF DEATH 1 Matural 5 Pending Investigation Provided B Could not be determined 28e. DATE OF INJURY 28b. Time Of NJURY Nursing Home 1/2 Residence Nursing Home 1/2	ALLABLE PRIOR TO DEATH? YES 2 NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 1 Imperient 2 ER/Outpettent 3 DOA OTHER: 1 Imp	ALLABLE PRIOR TO DEATH? YES 2 NO NO NO NO NO NO NO NO NO NO NO NO NO N
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 No YES 2 NO THER: 1 Inpetient 2 ER/Outpatient 3 DOA A Nursing Home Still Residence 8 Other (Specify) 27. MANNER OF DEATH 1 Noturel 5 Pending Investigation 3 Suicide 8 Could not be determined 28e. DATE OF INJURY At home, term, street, factory, office 28c. INJURY AT WORK? 29e. CERTIFIER (Check only one) 29e. CERTIFIER (Check only one) 29e. CERTIFIER (Check only one) 29e. CERTIFIER (Check only one) 29e. SIGNATURE AND TITLE OF CERTIFIER 29e. SIGNATURE AND TITLE OF CERTIFIER 29e. LICENSE NUMBER 29	ALLABLE PRIOR TO DEATH? YES 2 NO NO NO NO NO NO NO NO NO NO NO NO NO N
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Inpatient 2 ER/Outpattent 3 DOA 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 3 Sulcide 4 Could not be determined 28. PLACE OF INJURY — At home, term, street, factory, office 29. CERTIFIER (Check only One) 29. CERTIFIER (Check only One) 29. MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, deta and pieca, and due to the ceuse(e) end menner ee stated. 29d. DATE SIGNED (Mo	ALLABLE PRIOR TO MAPLETION OF CAUSE DEATH? YES 2 NO Re Number, and manner se stated, onth, Day, Year) , 1995



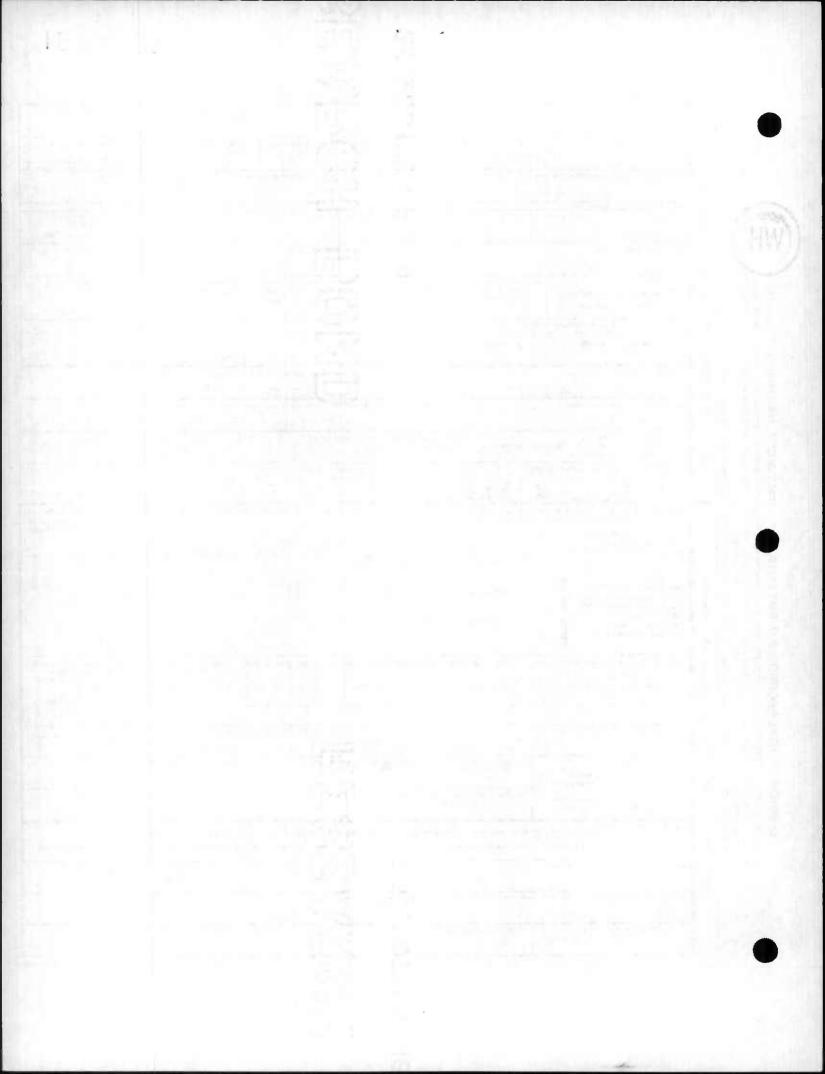
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR		CE	RTIF	CATE O	F DEATH		REG. NO.			
1. DECEDENT'S NAME (First, Middle, Lest)			_			2. DAT	E OF DEATH			3. TIME OF DEATH
John G.	Fr	itz					2-1-19		YEAR	3:40am м
4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. lest		IF UNDER 1 YEA		7. DAT	F OF BIRTH		8. BIRTH	PLACE (State or Foreign
141-10-3768	1 🔀 M 2 🗆 F	92	YRS.	MONTHS DAY	8 HOURS MIN,		1th, Day, Year)	002	N e T	y York
9a. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY, TOW	N OR LOCATION OF				NTY OF D	
Chesapeake Mand	r N H		1	Λ -	cnold					
RESIDENCE OF DECEDENT	Z N · II ·			- A 1	11014	-		A.	nne	Arundel
10a. STATE 10b. COUNTY			10c. CITY,	TOWN OR LO	CATION					10d. INSIDE CITY
MD Anne	Arunde	1		Arno	Ld					LIMITS?
10e. STREET AND NUMBER					101. ZIP CODE			10g. CITI	ZEN OF V	WAT COUNTRY?
College Parkwa	ı V				21012	•			USA	
11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. ARI	MED	13, WAS [DECENDENT OF HISP		IN? (Specify Yea			— American Indien,
1 Never Married 2 Merried	FORCES? 1	YES 2 N	0	If yes,	specify Cuben, Mexic	cen, Puerto	Rican, etc.)	0. 1.0	Black	, White, etc.
3 X Widowed 4 Divorced		OII DAILED		1 '0'	ES 2 XNO Spec	ату:			Speci	•
15. DECEDENT'S EDUC	ATION	16a. DEC	CEDENT'S U	SUAL OCCUP	ATION	16	b. KIND OF BUS	INESS/INC	USTRY	White
(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Girl	ne kind of wo Do NOT use	retired.)	most of working					
11		М.	achi	nist			Pan	er	0.0	
17. FATHER'S NAME (First, Middle, Last)		11	aciii	HISC	16. MOTHER'S N	AME (First	Middle, Meiden		00.	
John G. Fritz.	Sr							- united		
19e. INFORMANT'S NAME (Type/Print)	J.L.	104	MAILING	DDRESS /C/	M a. I	gar		Cinta T	Code	
Hillian Prin						- /				22122
William Fritz 200. METHOD OF DISPOSITION				A IN D C I	wood	S.				
1 Buriel 2 Cremetion 3 Remo	val from State	cemetery, cren	natory or oth	er place)		1		CATION -	City or To	wn, Stata
21. BIGNATURE OF FUNERAL SERVICE LIC	INSEE.	LMetr	o Cr	emato	AND ADDRESS OF F	2	1 Cat	ons	vill	e. MD
	12			22. NAME	AND ADDRESS OF F	ACILITY	4	95 1	Rito	hie Hwy.
I Colli	Jann			Barı	anco Fu	ner				na ParkMD
23. PART I. Easer the disesses, or c	omplications that c	aused the dea	th. Do no	t enter the	mods of dying, su	ch as ce	rdisc or respir	ratory srr	est,	Approximate
IMMEDIATICAUSE (Final	lat only one ceuse	on each line.								Interval Between Onset and Death
	Con	01/0-	44	IN	SUCCL	161	./:			Onset and Death
resulting in death)		AS A CONSEO		, , , .	308000	100				
	•		,							
Sequentially list conditions, if any, leeding to immediate	DUE TO (OF	AS A CONSEC	UENCE OF)							
csuse. Enter UNDERLYING	(0	NON	N	AM-	7 Cm > 1	21.5	6056	-		İ
CAUSE (Disease or Injury that initiated events		AS A CONSEC		, ,	C /		0 11- 0			+
resulting in death) LAST										
PART II. Other significant conditions		eth but not re	sulting in	ths underly	ing ceuse given in	Part I.	24s. WAS AN A		24b.	WERE AUTOPSY FINDINGS MAILABLE PRIOR TO
coron cam	tor,						1 TYES 2	. /		COMPLETION OF CAUSE OF DEATH?
					-			V		1 YES 2 NO
DID TOBACCO USE CONTR	IBUTE TO CAUS	SE OF DEAT	'H YES	☑ NO	UNCERTA	NΠ				
25. WAS CASE REFERRED TO MEDICAL				(Check only o		-				
EXAMINER?	HOSPITAL:	VOutpatient 3		OTHER:	ome 5 - Residence	i D An	(Passit)			
27. MANNER OF DEATH	28e. DATE OF IN.		28b. TIME		NJURY AT		er (Specify) SCRIBE HOW IN	IIIBY OCC	NIDED.	
EZ. MARRIER CO DEATH	(Month, Day,	Year)	INJU	RY	WORK?	100.00	JOINDE HOW IN	DON'T OCC	ONED	
1 Natural 5 Pending	(Intoriari, Day,			M 4 €	VES 2 NO					
1 Natural 5 Pending Investigation		JURY — At hon	o form etc		YES 2 NO	204 1 0	CATION (O			
J Natural 5 Pending	28e. PLACE OF IN building, etc.	IJURY — At hon (Specify)	ne, farm, str			28f. LO	CATION (Street er or Town, Stete)	nd Number	or Rural R	oute Number,
Netural 5 Pending Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF IN building, etc.	(Specify)		eet, fectory, o	flce	City	or Town, Stete)			oute Number,
Natural 5 Pending Investigation 1 Suicide 4 Hamicide 29e. CERTIFIER (Check only 1 CERTIFYINO PHYSIC	28e. PLACE OF IN building, etc.	knowledge, dea	th occurred	eet, fectory, of	fice	e to the ca	or Town, Stete)	ner es state	ed.	
S Pending Investigation I Builcide Homicide 29e. CERTIFIER (Check only)	28e. PLACE OF IN building, etc.	knowledge, dea	th occurred	eet, fectory, of	fice	e to the ca	or Town, Stete)	ner es state	ed.	
Natural 5 Pending Investigation 1 Bulcide 4 Hamicide 29e. CERTIFIER (Check only 1 CERTIFYINO PHYSIC	28e. PLACE OF IN building, etc.	knowledge, dea	th occurred	eet, fectory, of	fice	e to the ca	or Town, Stete)	ner es state	ed. e cause(e)	
S Could not be determined 2 CERTIFIER (Check only one) 2 MEDICAL EXAMINER	28e. PLACE OF IN building, etc.	knowledge, dea	th occurred	eet, fectory, of	fice ste end placs, end du , death occured at th	e to the ca	or Town, Stete)	ner es state	ed. e cause(e)	end menner es stated.
Natural 5 Pending Investigation	28e. PLACE OF IN building, etc.	knowledge, dear	th occurred	est, fectory, of at the time, d	ete end placs, end du , death occured at th	e to the ca	or Town, Stete)	ner es state	ed. e cause(e)	end menner es stated.
Signature and Title OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER	28e. PLACE OF IN building, etc.	knowledge, dear	th occurred evention,	eet, fectory, of at the time, d in my opinion	ete end place, end du , death occured at th 29c. LICENSE NU	e to the ca e time, det	v or Town, Stete)	due to the	e cause(e)	end menner ee stated. (Month, Day, Year) 7 5
Solution Solution	28e. PLACE OF IN building, etc. SAN: To the best of my On the basis of exam COMPLETED CAUSE OF SAN GOV. 32. REGISTRAR'S	knowledge, dea institution end/or in DF DEATH (ITEM 27	th occurred evestigation, 27) (Type, F	eet, fectory, of at the time, d in my opinion	ete end placs, end du , death occured at th	e to the ca e time, det	v or Town, Stete)	due to the	e cause(e)	end menner ee stated. (Month, Day, Year) 7 5

0, BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within rouns after death. Page 6 may be retained by the hospital or attending physicial	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tribe filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	. The law requires that the death certificate be executed	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the I be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	tem 23 shows any injury, or other traumatic ev
DIVISION OF VI	TO THE HOSPITAL OR ATTENDING PHYSICIAN:	TO THE FUNERAL DIRECTOR: After this certificate be filed within 72 hours after death with the St	IMPORTANT: If Item 28 is marked, or it

	1 - STATE REGISTRAR	STATE OF MARYLA		IENT OF HEALT		ENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Lest) Muriel V. Fabe:	rt		270)		P. DATE OF DEATH DATE OF DATE OF DEATH DATE OF DATE		year 995 9:00 A M
	4. SOCIAL SECURITY NUMBER 366-24-7713 96. FACILITY NAME (If not institution, give st	1 □ M 2 □ F 81	YR\$, MOI	UNDER 1 YEAR IF UND OTHER DAYS HOURS CITY, TOWN OR LOCA	MIN.		.913	BIRTHPLACE (State or Foreign Country) North Carolina Y OF DEATH
HOL	4219 Kenshaw Ave	nue	- 6-	Baltimore			Bal	timore
L DIRECTOR	10e. STATE 10b. COUNTY	altimore		own or Location Itimore I 101, ZIP CO	NOE.		40- CITIZE	10d. INSIDE CITY LIMITS? 1 YES 2 NO
BY FUNERAL	4219 Kenshaw Aver 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 1 YES IF YES, GIVE WAR OR DA	2 W O	21	215 OF HISPANIC ben, Mexican, I	ORIGIN? (Specify Yea Puerto Rican, etc.)	Unite	ed States 4. RACE — American Indian, Black, White, etc. Specify: White
COMPLETED	15. DECEDENT'S EDU((Specify only highest grade Elementary/Secondary (0-12) 12	CATION completed) College (1-4 or 5+)	16e. DECEDENT'S USU (Give kind of work Me. Do NOT use rel Librari	done during most of wor tired.)	king	Beauty		
BE	17. FATHER'S NAME (First, Middle, Last) William Rob: 190. INFORMANT'S NAME (Type/Print)	inson	19b. MAILING ADI	Statement I am	rene	(First, Middle, Meiden Prince the Number, City or Tow		ode)
2	Raymond Worley 20e, METHOD OF DISPOSITION 1 M Burlel 2 Cremelton 3 Remo	20b.	9570 Ba	sket Ring	Road (Columbia,	Mary CATION - CH	land 21045 ty or Town, Stata
	21. SIGNATURE OF FUNERAL SERVICE LIC		etery, cremetory or other t. Johns	Harry H	ress of facil Vitzke	Funeral	Home 1	City, MD Inc ott City 21043
CEHILICATION	23. PART I. Enter the disease, or on shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. DUE TO (OR AS A	CONSEQUENCE OF):					Interval Between Onset and Death
MEDICAL	PART II. Other significant condition	contributing to death bu	at not resulting in the	ne underlying ceus	given in Pa	24a. WAS AN PERFOR	IMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
H TSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpa		THER:	DEATH (Check			
DI PHI	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	20e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF	Nursing Home 5 D Sec. INJURY AT WORK? M 1 YES 2	2	ed. OESCRIBE HOW II	NJURY OCCU	RED
	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, etc. (Special	— At home, farm, stree fy)	t, factory, office	2	61. LOCATION (Street a City or Town, State)	and Number or	Bural Route Number,
IO BE COMPLETED	and a	COMPLETED CAUSE OF DEA	and/or Investigation, in TH (ITEM 27) (Type, Print)	my opinion, death occ		ne, date end place, en	d due to the	couse(e) and manner se stated. SIGNED (Month, Day, Year)
	1 50 0 0 100	Jaha diwale	me of the to Comy	2711				



BALTIMORE, MARYLAND 21215-0020	cours after death. Page 6 may be retained by the hospital or attending physician.	filled in by the funeral director, page 5 should be detached for use as the burial-transit pion, or removal.	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the world and the death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this cardificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit per filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF	MARYLAN	D / DEPAR					MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE	OF DEATH			3. TIME OF DEATH
	1	Hilda	Louise	Bra	shea	r F	ree		MONT	lary L	,199	YEAR	
	4. SOCIAL SECURITY NUMBER	5. SEX		rs. last birthday)		R t YEAR				ualy L	9エフフ.	2	11:45 P w
		1 M 2 TF		YRS.	MONTHS	DAYS	HOURS	MIN.	(Month	OF BIRTH		Counti	
	215-18-1233	45	72	THS.						ch 6,1	922	Ma:	ryland
_	9a. FACILITY NAME (If not institution, give s				9b. CIT	Y, TOWN	R LOCATE	ON OF D	EATH		9c. COU	NTY OF D	EATH
6	5611 Old New	Market	Road			Ne	w Ma:	rket	,			Fre	derick
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY												
DIREGROR				10c. CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY LIMITS?
		derick				Ne	w Ma:	rket	,				1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER					101	. ZIP COD	ε			10g. CIT	ZEN OF V	VHAT COUNTRY?
H	5611 Old Net	w Market	Road				21	774			III	nite	d States
5	11. MARITAL STATUS	12. WAS DECEDE	NT EVER IN U.S	S. ARMED	13.	WAS DEC			NIC ORIGIN	? (Specify Yes			
	1 Never Married 2 Married	FORCES?	1 YES 2	MO		If yes, sp		n, Maxica	en, Puerto I				E — American Indian, c, White, etc.
B	3 Widowed 4 Divorced		THE OTHER	1		1 123	Z-T- NO	Speci	у.			Spec	nite
	15, DECEDENT'S EDU	CATION	164	. DECEDENT'S	USUAL C	CCUPATIO	ON .		16b.	KIND OF BU	SINESS/INE		
ш	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5		(Give kind of life, Do NOT u	work done se retired.)	during mo	st of working	ng					
7	12	College (1-4 of 5	,	Pos	tmas	ton				II o	0		and.
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			105	ullas	rei.	40 14071	HEDIO M	100 151-1	Aiddle, Maiden	Gove	31.Dine	ent
	Ervin L. Br	an shoom					10. MO11						
H H		ashear								s Wolf			
2	19a. INFORMANT'S NAME (Type/Print)									oer, City or Tow			
- 1	Glenn Monroe	Free, S	r.	561	1 01	d Ne	w Mai	rket	Road	d, New	Marl	ket,	Md. 21774
	20a METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Rem	ours from State	20b. PL	ACE AND DATE	OF DISPO	SITION /Na	me of		DATE	E 20c. LO	CATION —	City or To	wn, State
	4 Donation 5 Other (Specify)	Over Hom State	_ Kemetar	rvin C	nape.	l Ce	mete	rv 2	18/91	5 M	t. A	rv.	Md.
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	0		22.	NAME AN	ID ADDRE	SS OF FA	CILITY			,7 ,	110.5
	100	111	<i>V</i> -	4						th, P.			
	cun	L. NI	ollow	nu		2640	L Ric	dge	Rd.,	Damas	cus,	Md.	20872
	23. PART I. Enter the diseases, or o shock, or heart fellure.	complications th	at caused th	a daath. Do	not anter	tha mo	da of dyl	ing, auc	h as card	lac or reap	ratory an	rest,	Approximata
- 1	IMMEDIATE CAUSE (Final	ciat only one ca	use on auch	III tel.									Interval Between Onset and Dasth
	diament of the state of	6-	aut.	a ==	7					6.			
- 1	resulting in death)	DUE TO	OR AS A CO	NSEQUENCE O	F):	2011.	>	0-1		/ 411	ح بر ن		1 WEER
,	_												3 weeks
፬	Sequentially list conditions,		OR AS A CO	NSEQUENCE O	F):	- 207							
<u> </u>	if any, leading to immediate cause. Enter UNDERLYING				_								i .
HILLCALION	CAUSE (Disease or injury	c. DUF TO	O LOTE AS A CO	NSEQUENCE O	99	no c	0,51			_			19-
ΞΙ	that initiated eventa resulting in dasth) LAST	346	JUII NO N 00	MOLOOLINGE O	,.								
		d											
3	PART ii. Other aignificant condition	a contributing to	death but r	ot rasulting	in tha w	darlying	L CAUSA C	alven in	Part i	24s. WAS AN	AUTOPSV	24b	WERE AUTOPSY FINDINGS
5		10 1								PERFOR		240	AVAILABLE PRIOR TO
5	150011	11/0	, ,	4 I		0 2	, -,		- 1	1 TYES 2	NO		OF DEATH?
Ξ													1 TYES 2 NO
z I	DID TOBACCO USE CONTR	RIBUTE TO CA	AUSE OF D	DEATH YE	S	NO D	b UNC	ERTAI	N 🗆				
PHTSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. 1	PLACE OF DEA		, ,							
5	1 TES 2 DIO	HOSPITAL: 1 Inpatient 2	☐ ER/Outpaties	mt 3 🗆 DOA	OTHE!		s.□ Re	sidence	8 Other	(Specify)			
ē	27. MANNER OF DEATH	28e. DATE O		28b. TIM	E OF	28c. INJ	JRY AT			CRIBE HOW I	NJURY OC	CURED	
	1 Natural 5 Pending	(Month,	Day, Year)	INJ	URY M		RK? 'ES 2	NO					
à	2 Accident Investigation 3 Suicide & Could not be	28a, PLACE	OF INJURY — /	At home, ferm,	street fac				281 1.00	ATION (Street a	and Mumbas	or Duni S	loude Mumber
급	S Could not be determined	building	, etc. (Specify)			,				or Town, State)	ING NUMBER	or nurai n	noble Number,
ij							_						
COMPLEIED	(Check only CERTIFYING PHYSIC												
5	one) 2 MEDICAL EXAMINE	R: On the basis of	examination and	d/or investigation	n, In my o	opinion, d	eath occur	red st the	time, date	and pleca, an	d due to th	a ceuse(a) and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER						29c. LICE						(Month, Day, Year)
	0		the										6, 1995
2	30. NAME AND ADDRESS OF PERSON WHO	0.00401 5250 533	100 OF 5515				111	146	26				-, -///
						Til.	no 2	ng -1-	1//	07.70	7		
	P. Gregory Raus			1 W 7t	JC II	. ا	rede:	T.T.C.K.	, FIG.	· <1/	1		
	31. OATE FILED (Month, Day, Year)	32. REGISTR	AR'S SIGNATUL	RE									
	FEB 1 0 1995	Diameter 1	astruction	- Redell	1								

The grant of the state of the s

29c. LICENSE NUMBER

Dr. Casper E. Cline, M.D., 300 West Winth Street, Frederick, Md. 21701

32. REGISTRAR'S SIGNATURE
Sala Drucker Rardally

Md. 2170

BE 2

31. DATE FILED (Month, Day, Year)

			FOR STATE REGISTRAR	STATE OF MA			TMENT OF			MENTAL HYGIEN	Ε		
			1. DECEDENT'S NAME (First, Middle, Last)	MILTON			TR.			2. DATE OF DEATH MONTH D	30, 199	YEAR	OF DEATH
	- I		4. SOCIAL SECURITY NUMBER 213-12-1273	1 🖟 2 🗆 F	AGE (In yrs. les	t birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS	MIN.	7. DATE OF BIRTH Sept. 14,		BIRTHPLACE	
	3 should	E E	9a. FACILITY NAME (If not institution, give Frederick Memor		al		9b. CITY, TOWN		on of De		9c. COUNT	Y OF DEATH	derick
_	2,	СТОВ	RESIDENCE OF DECEDENT						4677	OI.			del Tok
TH		DIRE		rederick		10c. CIT	Y, TOWN OR LOCAL					LII	SIDE CITY MITS? ES 2 ANO
111	1	VERAL	100. STREET AND NUMBER 4401 Tuscarora	Road			10	of. ZIP COD		790	10g. CITIZI	U.S	A.
	the burial-tr	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR	YES 2 2		If yes, s	CENDENT (pecify Cubs S 24 NO	n, Maxica	IIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No-	14. RACE — Ame Black, White, Specify:	white
or atte	for use as	COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Gi life.	Do NOT us		ION lost of worki	ng	16b. KIND OF BU			
Pospi C	once.	MP	17. FATHER'S NAME (First, Middle, Last)	2	I)	alry	farmer				y far	ming	
<u>ا ۾</u> ا	2 %	BE CC	Charles Milton Fr	y, Sr.				Mar	ME (First, Middle, Maiden y Alice Ti	tus			
be retaine	page 5 should be notified	10	Helen R. Fry		196					Houte Number, City or Tow Tuscaror			21790
			20a, METHOD OF DISPOSITION 1	noval from State S			Cente tery		Feb			of Roc	
death.	the Tuneral director, val. al examiner mus		21. SIGNATURE OF FUNERAL SERVICE LI	C. Basto	L MOO	021		eney	and	Basford F hurch St.,			Md. 217
nours at	completely filled in by the ial. cremation, or removal sevent, the medical or		23. PART I. Enfor the diseasea, or shock, or heart failura. IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause	on each line		not enter the m					st, A	pproximata itarval Between inset and Daath
ficate be execu	attending physician and commal Hygiene prior to burial, or other traumatic ev	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b		K D DUENCE OF	NS 0 N	1'5	37	SEASI			8475
, # ;	ed by the arte th and Mental any Injury,	EDICAL CE	PART II. Other algorificent condition	ns contributing to da	ath but not n	aaulting	In the undarlyli	ng cause	given in	Part I. 24a. WAS AN PERFOR	MED?	AMILAE	UTOPSY FINDINGS BLE PRIOR TO ETION OF CAUSE TH?
aw red	P 00	Σ	DID TOBACCO USE	CONTRIBUTE	TO CAU	SE O	DEATH	YES [] NO			1 🗆 YI	ES 2 NO
E E	State Dep	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			26. F	LACE OF D	EATH (Che	eck only one)			
ICIAN	1 to the	HYS	1 YES 2 NO 27. MANNER OF DEATH	1 Inpetient 2 EF			4 Nursing Ho		esidenca	6 Other (Specify)			
} ₹	wit with	ВУ РЬ	L Natural 5 Pending 2 Accident Investigation	(Month, Day,	Year)		M 1 🗆	JURY AT ORK? YES 2) NO	28d. DESCRIBE HOW I	NJURY OCCL	IRED	
ATTENDI	ter d		3 Suicide 6 Could not be datermined	26s. PLACE OF IN building, stc.	NJURY — At hou. . (Specify)	me, farm,	street, factory, offi	Ca		26f. LOCATION (Street a City or Town, State)	and Number o	r Rural Route Nur	nber,
		COMPLET		ICIAN: To the best of my ER: On the basis of axem									inner as stated.
우 :	2 5 5	O			1			1					

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

OHMH-16 Rev 1/89

The state of the s 1 3

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICAG

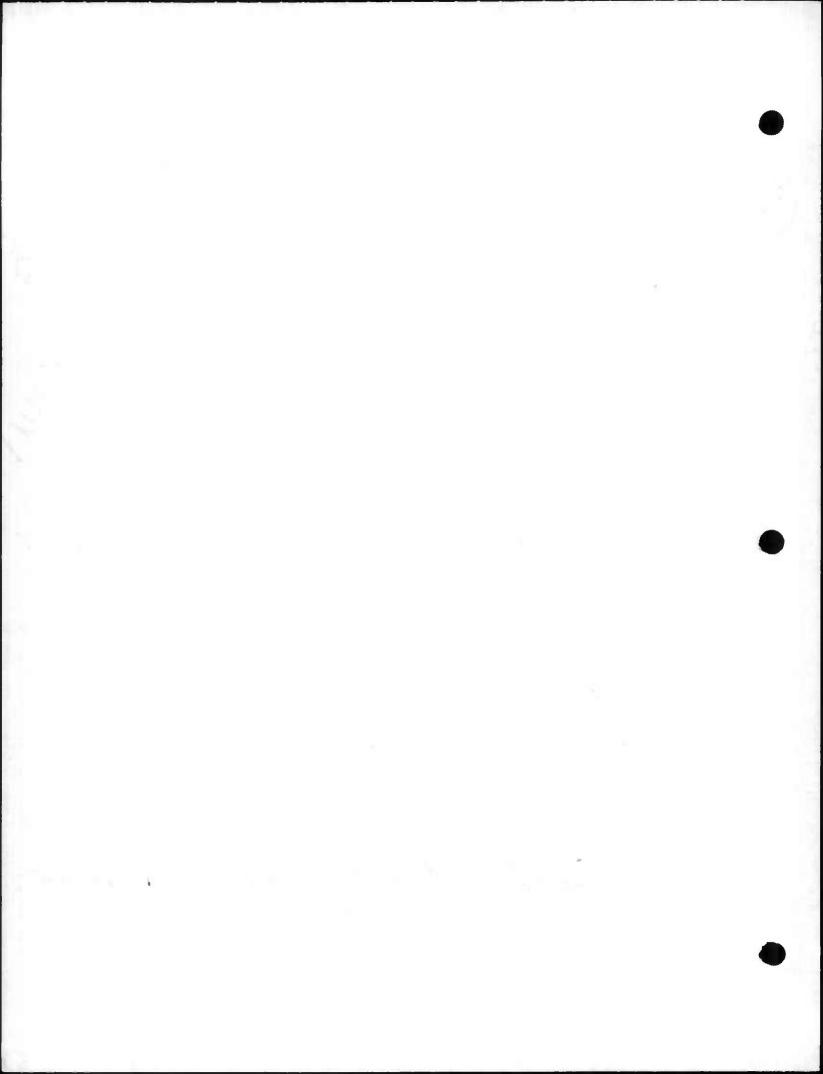
	1 - STATE REGISTRAR	OIAL OF M	CE	RTIF	ICATE				MENIAL F	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF		AV	VEAD	3. TIME OF DEATH
	Welby			Fren	ch			_	Januar	y 30), 199	5 YEAR	6:00 A M
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. last		IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF I	BIRTH by, Year)		6. BIRTH	PLACE (State or Foreign
	215-44-4999 9e. FACILITY NAME (If not institution, give s	1 🛣 M 2 🗆 F	49	YRS.					Jan. 2	20,			Maine
œ					ŀ		R LOCATIO	ON OF DE	ATH			NTY OF DE	
5	Potomac Valley No	irsing Hor	ne		Pot	omac					Mot	ntgom	ery
DIRECTOR	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN C	OR LOCATI	ION						10d. INSIDE CITY LIMITS?
۵		gomery		Pot	tomac	2							1 YES 2 NO
FUNERAL	100. STREET AND NUMBER					10f.	ZIP CODE				10g. CIT	IZEN OF W	THAT COUNTRY?
NE	1235 Potomac Vali						208					USA	
	1 Never Married 2 Married		YES 2 NO			f yes, spe	cify Cuba	n, Mexicar	IIC ORIGIN? (S n, Puerto Rica		or No-	14. RACE Black,	— American Indian, , White, stc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WA	R OR DATES		1	TES	2 📉 ND	Specify	·:			Specif	White
COMPLETED	15. DECEDENT'S EDUI (Specify only highest grade	CATION	16a. DEC	EDENT'S	USUAL O	CCUPATIO	N	_	16b, KIN	ID OF BU	SINESS/ING	DUSTRY	WILLEC
Ē	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Wa. E	Do NOT us	work done one retired.)		it of workin	g					
MP	12	0	Po	lice	Aid				Mon	tgom	ery (Count	y Police
8	17. FATHER'S NAME (First, Middle, Last) Russell W. French								ME (First, Middl		Surname)		
BE	19s. INFORMANT'S NAME (Type/Print)	1	L						lennage				
9	Valerie French								ofton,				1114
	20a. METHOD OF DISPOSITION		20b. PLACE AN					- 010				City or Toy	
- 3	1 ☒ Burisi 2 ☐ Cremation 3 ☐ Rem-	oval from State	Andrew C	natory or o	ther place) Meth	. Chu	rch C	em .	1				ginia
	21. SIGNATURE OF FUNERAL SERVICE UC	ENSEE	1100		22.	NAME AN	DADDRES	S OF FAC	Hine	es-R	inald	li Fu	neral Home
- 3	Mary Is	mit H	alla.	nd		1800	New	Han	pshire , Mary	e Av	enue	904	
	23. PART I. Entar tha diseases, or o	omplications that	caused the das	th. Do n	not anter	the mod	le of dyle	ng, such	as cerdiac	or resp	ratory sn		Approximate
	ahock, or heert failure. IMMEDIATE CAUSE (Final	List only one cause	e on each line.			_							Interval Between Onset and Death
	disesse or condition resulting in desth)	Cardu	ac a	7/	res	0							mmed
		Cardu	OR AS A CONSEOL	ENSE OF	F):	5			0		/		
No.	Sequentially list conditions,	MUNY	OR AS A CONSEDE	U2	0/1	C	N	200	ule	27	des	eas	4
F	If any, leading to immediate cause. Enter UNDERLYING	502 10 (0	AS A CONSEDE	ENCE OF	-):								
E	CAUSE (Disease or Injury that initiated avents	DUE TO (C	R AS A CONSEQU	ENCE OF	F):								-
CERTIFICATION	resulting in death) LAST	i											
	PART II. Other significant condition	s contributing to d	eath but not re-	eulting 1	n the un	derlying	COUICO O	hee to I	Part 1 04-	1400 044	AUTOPSY	1 400	WERE AUTOPSY FINDINGS
DICAL	stroke.	_				ocriying	couse g			PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MED	dialet 15								_ 10	YES 2	NO		OF DEATH?
	DID TOBACCO USE CONTE	RIBUTE TO CAU	SE OF DEAT	H YE	SΠN	ио П	UNC	ERTAIN	ī 🗖				1 YES 2 ND
N	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE										
PHYSICIAN	1 YES 2 ND	HOSPITAL:	ER/Outpatient 3	DOA	Nurs	t: Ing Home	5 🗆 Rei	sidence (6 Other (Sp	ecify)			
F	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF IN (Month, Day,		26b. TIMI	E OF URY	28c. INJU WOR	RY AT		28d. DESCRIE	BE HOW I	NJURY OC	CURED	
B≺	2 Aboldent Investigation				М		ES 2	NO					
	3 Suicide 6 Could not be 4 Homicide determined	building, et	INJURY — At home. (Specify)	o, farm, s	dreet, lacto	ory, office			281. LOCATIO City or To	N (Street a wn, State)	and Number	or Rural Ro	oute Number,
COMPLETED	29s. CERTIFIER									_			
MP	(Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of m											AND THE PARTY OF T
	290. SIGNATURE AND TITLE OF CHITINES		2	7	ii, iii my o					place, an			
8	11/1/1/	5	M	an	n		29c. LICE	NSE NUMI	O O				Month, Day, Year) 9NU 1995
일	30. NAME AND ADDRESS OF PERSON WHO	CDMPLETED CAUSE	DF DEATH (ITEM	27) (Type.	Print)		VL	110	70		- 9		, 0 11/1
	Walter E. Goozh, 1					i, Wh	neato	on. N	Maryla	nd	20902	2	
		1424 2307											
	31. DATE FILED (Month, Day, Year) FEB 01 1995	32. REGISTRAR			-								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the law requires that the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89



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	1	1	
l)	1	
,	d	-	

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21200 0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 73 hours after death. Page 6 may be retained by the pospital or attending physician and completely filted in by the funeral director, page 5 should be detached for use as the burial-tran be filed within 72 hours after death with the State Dept. of Health and Memai Hygiene prior to burial, cremation, or removal. DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

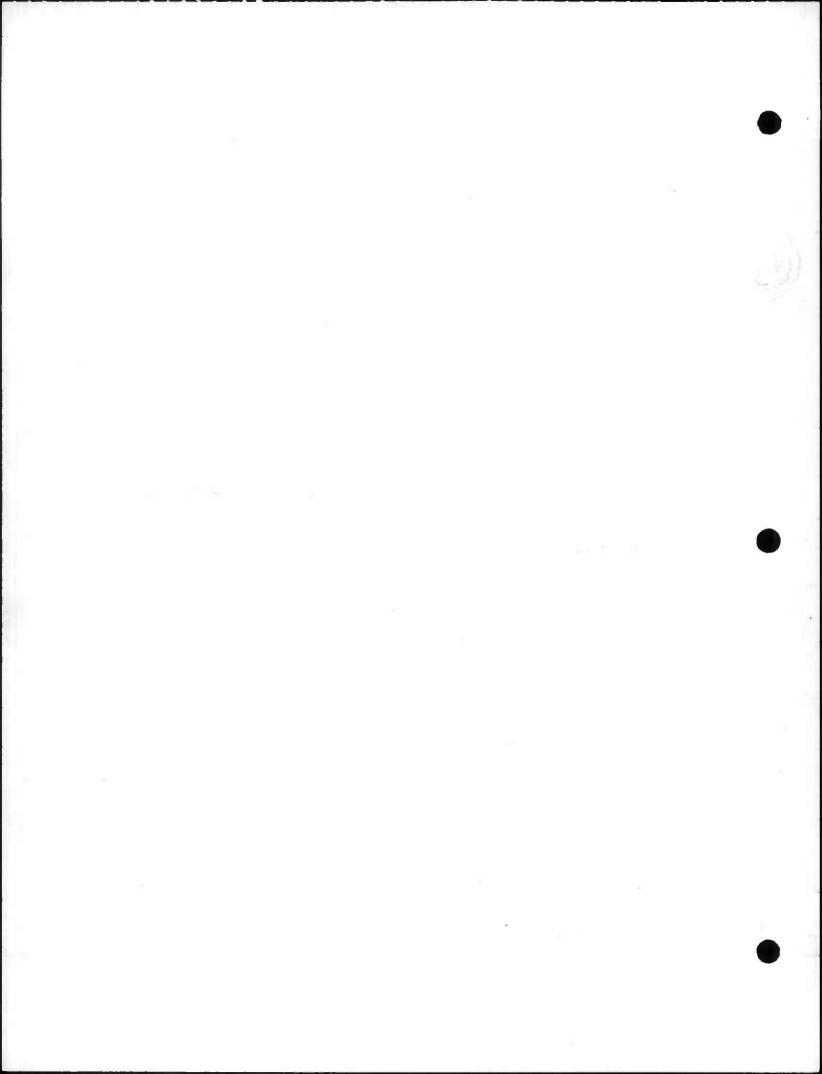
	REGISTRAR		CERT	IFICAT	E OF	DEATH		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	Martha	Torra Ex				2. DATE (OF DEATH	W	YEAR	3. TIME OF DEAT	'Н
		Martha K					Febr	uary	1, 19		4:08	PM
	ALTO CONTRACT CONTRACT		E (In yrs. last birth	day) IF UNDE	DAYS	IF UNDER 24 HRS.	7. DATE C	Day, Year)	-	8. BIRTH Countr	IPLACE (Stete or Fo	reign
	217 12 0000		7 Y	RS.	LAVIS	HOUNS MIN.		1-1-	1907		nington,	DC
	9e. FACILITY NAME (If not institution, give stre	set end number)		9b. CIT	Y, TOWN (OR LOCATION OF D	EATH			NTY OF D		
6	8500 River Road				Beth	esda			Mor	ntgon	nery	
5	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY											
풀			100	. CITY, TOWN							10d. INSIDE CITY	
0		gomery			ветп	nesda					t 🗌 YES 2 😥	NO
FUNERAL DIRECTOR	10e. STREET AND NUMBER				101	. ZIP CODE			10g. CIT	ZEN OF V	VHAT COUNTRY?	
ij l	8500 River Road					20817	7		Uni	ted	States	
ָהָּ		12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED	13.	WAS DEC	ENDENT OF HISPA	NIC ORIGIN	(Specify Yes	or No-	14. RACE	— American India c, White, etc.	in,
ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR				ecify Cuben, Mexics 2 NO Specif		ican, etc.)		Speci		
	A										White	
	t5. DECEDENT'S EDUCA (Specify only highest grade of	iTION ompleted)	18e. DECEDE (Give kin	NT'S USUAL (d of work done OT use retired.)	during mo	ON ost of working	16b.	KIND OF BUS	INESS/INC	USTRY		
"	Elementary/Secondery (0-12)	College (1-4 or 5+)							1	. 1		
M M		2	Regis	tered	Nurs	se	Pi	ublic	неат	tn		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, M	iddle, Meiden	Surname)			
BE	Enos C. Keys					Sarah N	10ugh:	lin				
5	19a. INFORMANT'S NAME (Type/Print)		19b. MAI	LING ADDRES	S (Street a	and Number or Rural	Floute Numbe	er, City or Town	r, State, Zip	Code)		
	Enos K. Fry		132	12 Lar	nterr	Hollow	Dr.,	Gaith	ersb	urg,	MD 2087	78
	20e. METHOD OF DISPOSITION 1 ☐ Burlet 2 ☑ Cremetion 3 ☐ Remove	20	b. PLACE AND D	ATE OF DISPO	SITION /Na	ama of	DATE	20c. LO	CATION -	City or To	wn, State	
į	4 Donetion 5 Other (Specify)	al from State Ca	Montary, cremator)	or other place	Feb	2, 199 orium,]	5 l	Ret	heed	a M	aryland	
	21. SIGNATURE OF FUNERAL SERVICE LICEN	egke	TOTTLEGOM	22.	NAME AN	A. Pump	CLITY	1 100	7	<u>u, 11</u>	aryrana	
- 1	10112	1	M001	$^{\circ}$	bert	A. Pump ethesda-0	hevy	Funer	alH	ome/		
	1 any	ann	M001	175	557 V	Visconsir	a Ave	. Beth	nesda	- MD	20814-35	501
	23. PART I. Enter the diseases, or con ahock, or haert fallure. Lie	mpilcations that cause at only one cause on	ed the daeth. I each line.	Do not ante	r the mo	de of dying, suc	h as cardi	ac or reaple	ratory arr	eat,	Approxima	
	IMMEDIATE CAUSE (Final		22								Onset and	
	disease or condition resulting in death)	Cardiac	Arrest								Immed	a.
		DUE TO (OR AS	A CONSEQUENC	E OF):								
Z	Sequentially list conditions, b.				scula	ar Diseas	se				Years	
CERTIFICATION	if any, leading to immediate	DUE TO (OR AS	A CONSEQUENC	E OF):								
2	CAUSE (Disease or Injury											
# I	thet initisted events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENC	E OF):								
E I	d.											
	PART ii. Other algnificant conditions	contributing to death	but not result	na in the w	nderlylne	r cettee given in	Part I	24e, WAS AN	ALITORAY	0.00	WERE AUTOPSY FII	
EDICAL					. activity	g couse given in	Y diletti.	PERFOR		240.	AMAILABLE PRIOR	ro
<u>a</u>							-	1 TYES 2	₩ NO		OF DEATH?	AUSE
Σ											1 TES 2XXN	10
z	DID TOBACCO USE CONTRI	BUTE TO CAUSE (OF DEATH	YES	NO 🛭	UNCERTAIN	V 🗆					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF									
YSI	1 X YES 2 □ NO 1	□ Inpatient 2 □ ER/Out	tpatient 3 🗆 OC	OTHE		e 5X Residence	6 🗆 Other	(Specify)				
표	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Yeer)	28b.	TIME OF INJURY	28c. INJI	URY AT RK?	28d. DESC	RIBE HOW IN	JURY OCC	URED		
B≺	1 Natural 5 Pending 2 Accident Investigation			М		ES 2 NO						
	3 Suicide 8 Could not be	28e. PLACE OF INJUR building, atc. (Spe	Y — At home, fa	rm, street, fac	tory, office		28f. LOCAT	TION (Street e. Town, State)	nd Number	or Aural A	bute Number,	
	4 Homicide determined		, , , , , , , , , , , , , , , , , , ,				City or	iown, State)				
COMPLETED	29e. CERTIFIER (Check only	AN: To the best of my know	wiedge, death oc	Curred at the	time dete	and place, and due	to the ease	o(a) and man		4	·	
ž	(Check only one) 2 MEDICAL EXAMINER:										and manner se et	et a d
					and the second of			prece, enc				
띪	29b. SIGNATURE AND TITLE OF CERTIFIER	1 11.	C1.6			29c. LICENSE NUN		I			(Month, Day, Year)	
2	JAMAN T	Maril	m.	<u> </u>		D17935			Pr'eb	. 2,	1995	
	30. NAME AND ADDRESS OF PERSON WHO				~*		-	-		00		
1	Sands Irani, M.D.	. 5530 Wis	consin	Avenue	e, Ch	nevy Cha	se, M	arylar	nd 2	0815		
	ST. DATE FILED (Month, Day, Year)	REGISTRAR PSIGN	ATUBE									
il.	PER UDITATE ANNO	Am many a man	Annah									- 1

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR

1 - STATE REGISTRAR	SINIE UF W	IANTLAND /		ICATE				MENIA	REG. NO	_		
1. DECEDENT'S NAME (First, Middle, Last)									E OF DEATH			3. TIME OF DEATH
PAUL ELV:	IN	FOO)R					MON'		AY 1 1	YEAR	4:55 A M
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		IF UNDER 1 Y	EAR I	IF UNDER	24 HRS.	7. DATE	CHARY E OF BIRTH		8. BIRTH	IPLACE (State or Foreign
190-28-1101	1 📉 M 2 🗌 F	56	YRS.	MONTHS 0	MYS H	HOURS	MIN.		th, Day, Year) Ly 26	1938	PA	γ)
9a. FACILITY NAME (If not institution, give st	reet and number)			96. CITY, TO	OWN OR	LOCATIO	ON OF DE				NTY OF D	EATH
Memorial Hospital	& Medica	al Cente	er	Cumb	erla	nd					A 1 1 a	
RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY								7	- 01		ALIE	gany
			1.00	r, TOWN OR I				1 SV	17 pm			10d. INSIDE CITY LIMITS?
PA Bedf	oru		W	. Prov		II CODE		1	-	Total and		t 🕅 YES 2 🗌 NO
RD 4 Box 50						537						VHAT COUNTRY?
11. MARITAL STATUS	12. WAS DECEDENT	FVFR IN U.S. AR	MED	12 WM	1		E WIEDAN	HC OBICE	IN? (Specify Ye		U.S.	
1 Never Married 2 X Married	FORCES? 1 IF YES, GIVE W	X YES 2 N	10	If yo	es, specif	fy Cubar	n, Mexicar	n, Puarto	Rican, etc.)	or No—		— American Indian, c, White, etc.
3 Widowed 4 Divorced	W 123, GIVE 10	AN ON DATES		'') TES 2	Mino	Specify	r:			Spec Wh	ite
ts. DECEDENT'S EDUC (Specify only highest grade	CATION completed)			USUAL OCCL		of secondary		16	b. KIND OF BU	SINESS/IN	_	
Elementary/Secondary (0-12)	College (1-4 or 5+	life.	Do NOT us	e retired.)	ng most t	or working	9					
12		Γ	ruck	Drive	er				Comme	ercia	.1	
17. FATHER'S NAME (First, Middle, Last)					1				Middle, Maiden	Surname)		
Blair L. Foor						Io			iehl			
190. INFORMANT'S NAME (Type/Print) Betty Foor		198	_						nber, City or Tow	n, State, Zij	Code)	
20g, METHOD OF DISPOSITION		20020	RD 4				eret	_	-			
1 N Buriel 2 Cremetion 3 Remo	eval trom State	cemetery, cree Bedfore	metory or oti	her place)	orial	Par	· 2	/4/95		cation — ford,		
21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	Ledion	Codi				S OF FAC	1,	bcu	toru,		3322
·// ///	22/1	1 10/1/2							al Ser	vice	, In	2.
depl	WELL	all		P.O.	Bo	x 17	79 1	Ever	ett. P	A 1	5537	
23. PART i. Enter the diseases, or c shock, or heart fellure. I	omplications that liet only one caus	ceused the de se on each line	sth. Do n	ot enter the	e mode	of dyli	ng, such	h as car	disc or resp	iratory ar	reat,	Approximate interval Between
IMMEDIATE CAUSE (Finel disease or condition	D~.	- 6 1 0 0	Α. `.	0	n k	6	10 -	- 0.0	la.			Onset and Death
resulting in death)	101	nore	MIC	(NI	UV	AIRA	VU)			14 luns
	DUE TO	OR AS A CONSEC	O O	2								12
Sequentially list conditions,	DUE TO	OR AS A CONSEC	UENCE DE) / 1	>	1						3 my
if any, leading to immediate cause. Enter UNDERLYING	Ma	San	Cont	1	80	71	W)	/			
CAUSE (Disease or injury that initiated events	DUE TO	OR AS A CONSEC	UENCE OF	3 1	1							
resulting in deeth) LAST	. In	GCAC	ichl	0	91	V						
PART il. Other eignificant conditions	contributing to	dooth but not a	del de		-11							
TATO II. OTHER DISTRICTION	contributing to	neern but not h	eeuiting ii	n the unge	riying c	ause g	iven in i	Part I.	24a. WAS AN PERFOR	RMED?	24b	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
									1 TYES 2	NO		OF DEATH?
DID TORACCO LISE CONTR	IDLITE TO CAL	ICE OF DEAT	TIL VE	C 🗆 NG		111116	EDTAIN					1 TES 2 NO
DID TOBACCO USE CONTR	IBUIE IO CAL			H (Check only		UNC	EKIAIN	<u>ч П</u>				
EXAMINER?	HOSPITAL:		_	OTHER:								
27. MANNER OF DEATH	28a, DATE OF	NJURY	28b. TIME	4 Nuraing	c. INJUR		eldence (-	er (Specify) SCRIBE HOW I	N.HIBY OC	CUREO	
1 Netural 5 Pending	(Month, Da	y, Year)	INJ	URY	WORK	7	NO		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		OUNED	
2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF	INJURY — At hor	me, ferm, st					28t. LO	CATION (Street)	and Number	or Rural F	loute Number
4 Homicide determined	building, e	etc. (Specify)					- 1		or Town, State)			
29a. CERTIFIER 1 CERTIFYING PHYSIC	JAN: To the heat of	TIV knowledge de	th occurr	d at the sum-	deta ac	d place	and door	to the -	unale) and —		had.	
) and menner ea stated.
29b. SIGNATURE AND TITLE OF CERTIFIER							NSE NUM		,			(Meven, Day Year)
	Nh-				1.			and the		b.	2/1	195
30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E OF DEATH (ITEM	1 27) (Type,	Print)	D	233	/1				11	/ //
Dr. Zaman Johnson	Hohts 1	Tenibal	R11 1 7	dina	C,, 4 +	1	02 0	71	1 - 1	344	- 1	1.000
31. DATE FILE D. 0 7 1995	Hghts.	Medical	Buil	ding	Suit	e 1	02 0	lumb	erland	, Md		21502





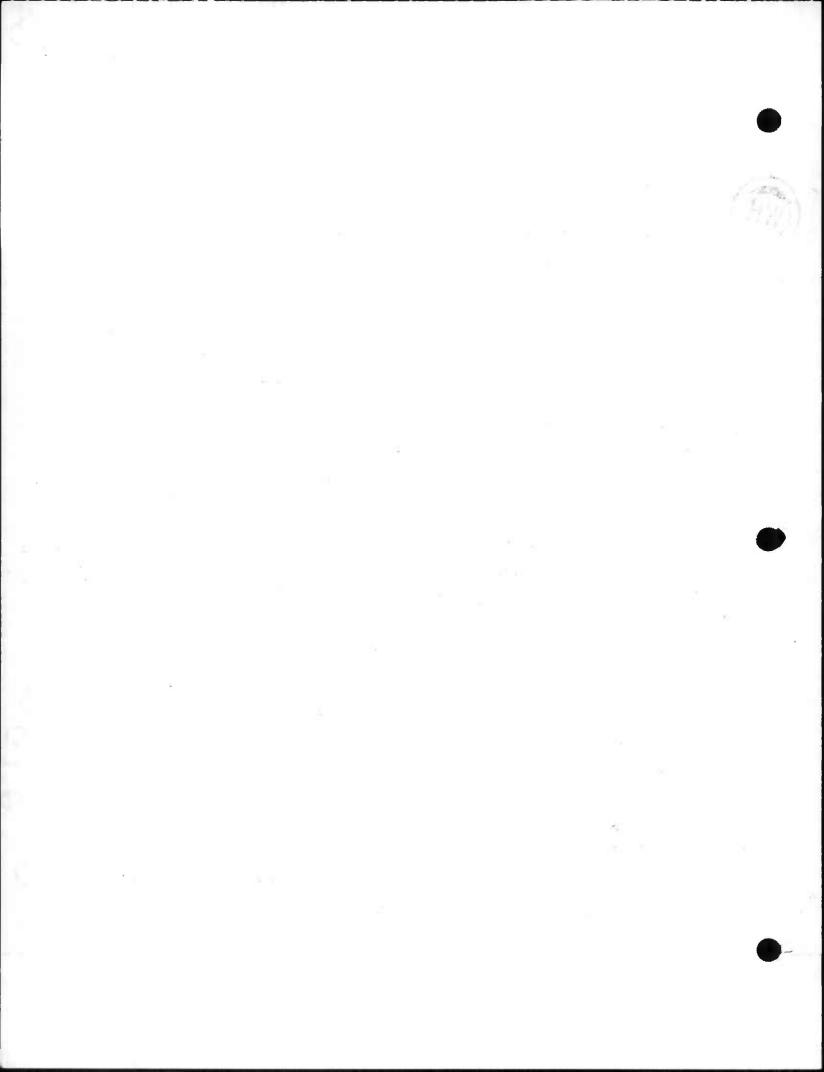
IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

Amended	*
FOR STATE BEGISTRAD	

199 2/1/95 MRT Monta

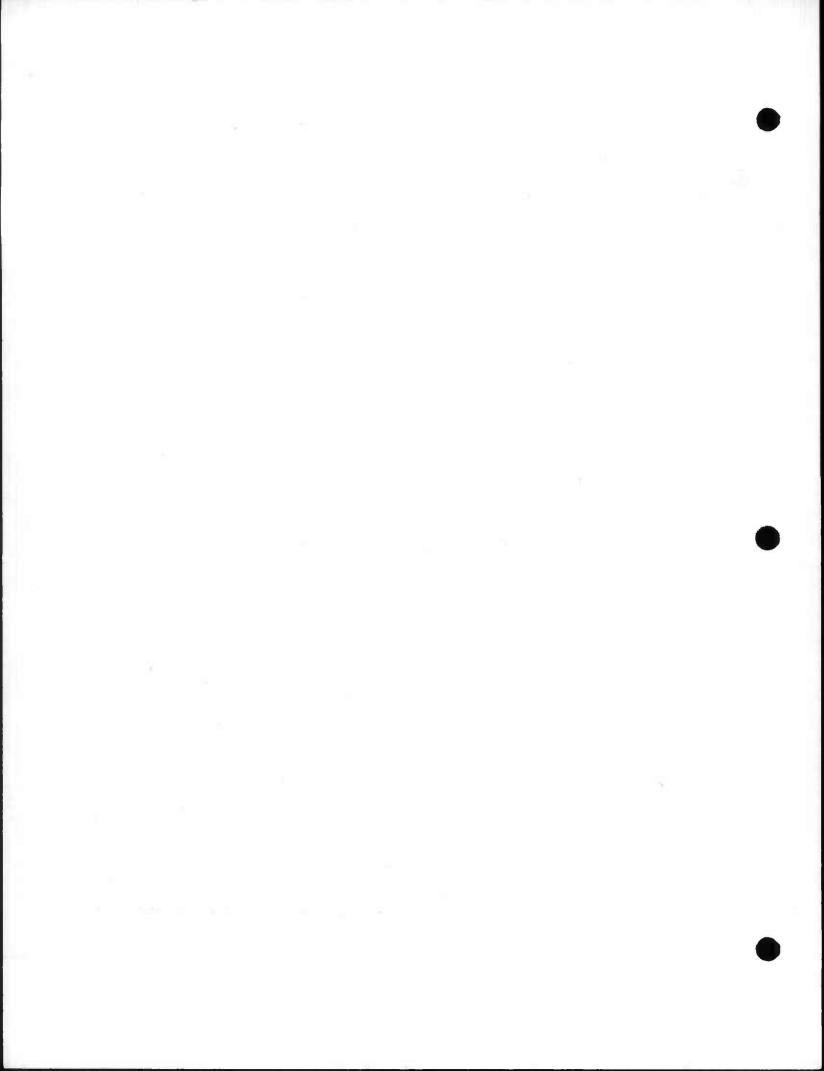
	1 - STATE REGISTRAR		CE	RTIF	ICATE O	F DEAT	H	1/	EG. NO		ア		4
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF I	-	414		3. TIME OF DEA	TH
	BRUCE MILLAR	FORRI	ESTER					JAN.	30,	19	95 ^{YEAR}	12:30	P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	t birthday)	IF UNDER 1 YEAR			7. DATE OF E (Month, De	BIRTH 1	908	8. BIRTN	PLACE (State or F	oreign
	486-01-2296	1 X M 2 - F	86	YRS.	MONTHS DAYS	HOURS	MIN.	Decemi	ner)-	26	Mico	souri	
	9a. FACILITY NAME (If not institution, give street	et and number)			96. CITY, TOW	OR LOCATIO	N OF DE			-	UNTY OF D		
DIRECTOR	7017 Beechwood Dri	Lve			Chev	y Chas	e			M	lontgo	mery	
E C	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR LOC	ATION						10d. INSIDE CIT	Υ
8	Maryland Montgo	omerv		Ch	evy Cha	se						LIMITS?	I NO
	10e. STREET AND NUMBER					IOI. ZIP CODE				10g. CI	TIZEN OF W	HAT COUNTRY?	
FUNERAL	7017 Beechwood Dri	ive				208	15			υ	S.A.		
ا ۾		2. WAS DECEDEN	IT EVER IN U.S. ARI	MED	13. WAS D	ECENDENT OF	HISPAN	IIC ORIGIN? (S	pecify Yes	or No-	14. RACE	- American Ind , White, etc.	len,
ВУ	1 Never Married 2 XXMarried 3 Wildowed 4 Divorced	IF YES, GIVE W	WAR OR DATES			ES 2 X NO			i, arc.)		Speci		
	15. DECEDENT'S EDUCAT	World Wa										ite	
1	(Specify only highest grade co	mpleted)	(Gi	ve kind of a	USUAL OCCUPA work done during i	TION most of working	9	16b. KIN	O OF BU	SINESS/II	NOUSTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 + 5+	+)		l Judge			Т.	aw				
MO	17. FATHER'S NAME (First, Middle, Last)	J.	116	uera.	1 Juage	10 MOTH	ED'S NA	ME (First, Middle		C			
Ü	James Millar Form	cester				10. 11.		tha Wi		,			
m	19a. INFORMANT'S NAME (Type/Print)	Forre	octov 196	. MAILING	ADDRESS (Stree	t and Number	or Rurai F	Route Number C	ity or Tow	n State 2	7/o Codel		
5	Anne Lee Broaddus				Beechw							0815	
1	20a, METHOD OF DISPOSITION		20b. PLACE A	ND DATE	OF DISPOSITION /	Name of		DATE			- City or To		
	1 X Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	al from State	Fores	metory or o	ther place)	terev		2/11			City		
I	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE /			22. NAME	AND ADDRES		CILITY					
!	> 4M1911	y eter	2									Wiscons	sin
	23. PART I, Enter tha diseasea, or con	mplications tha	t caused the de-	ath Do r	Aven	ue, Nh	l Was	shingto	on,	DC 2	0016	Approxim	
	ahock, or haart fallure. Lis	it only ona cau	ise on aach lina.			loca or cyn	rg, adoi	i de cardiac	or reap	natory a	11001,	Intarval B	etwean
	IMMEDIATE CAUSE (Final disease or condition	Rose	alcana		Eail	UCE						Onset an	d Daath
i	reaulting in death)	DUE TO	OF AS A CONSEC	UENCE O	F):	71						3 WE	573
z		mye	OR AS A CONSECUTION OF AS	010	sotic 1	PNU	4	0 0.02	S'A			5 ur	905
은	Sequantially list conditions, if any, leading to immediate	DOE TO	OR AS A CONSEC	UENCE O	F):		7-1-	1				1	
S	CAUSE (Disease or Injury	2,6	vere 1	Hne	min								
늗	that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSEO	UENCE O	F):								
CERTIFICATION	d.											-	
١٢	PART II. Other significant conditions of	contributing to	death but not re	eaulting	in the underly	ng cause g	iven in	Part I. 24a	. WAS AN	AUTOPSY	24b.	WERE AUTOPSY F	INDINGS
DICAL									PERFOR			AVAILABLE PRIOR COMPLETION OF	
LLI H								_ '	YES 2	NO.		OF DEATH?	
W.	DID TOBACCO USE CONTRIB	BUTE TO CA	USE OF DEAT	TH YE	S 🗆 NO	M HINCH	ERTAIN					1 YES 2	NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				TN (Check only on			·		-			
Sic		IOSPITAL:	ER/Outpatient 3	□ DOA	OTHER: 4 Nursing He	me 5 🗆 Res	idenca	8 Other (So	ecity)				
Ě	27. MANNER OF DEATH	28a. DATE OF (Month, De	INJURY	28b. TIM	E OF 28c. II	JURY AT	T	28d. DESCRIE		NJURY O	CCURED		
BY	1 Natural 5 Pending 2 Accident Investigation	(MONN, D	uj, reary	ma		YES 2	NO						
- 10	3 Suicide 8 Could not be	28e. PLACE Of	F INJURY — At horate. (Specify)	ne, farm, e	treet, factory, of	Ice		28f. LOCATION		nd Numb	er or Rural R	oute Number,	
COMPLETED	4 Nomicide determined							Only of 101	WII, SIEIG				
21	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIA	N: To the beat of	my knowledge, dea	ith occurr	ed at the time, da	te and place,	and dua	to the cause(a)	and man	mer aa at	ated.		
8	onel PEDICAL EXAMINER:											and manner as a	itated.
	296L BIGHATURE AND TITLE OF CENTIFIER	/		/	1	29c. LICEI						(Month, Day, Year)	
BE	4/00/1	lec.	vydn	1		Da		83		•	1/3	0/95	
2	30. NAME AND ADDRESS OF PERSON WAS	OMPLETED CAUS	SE OF DEATH (ITEM	27) (Type,	Print)			4)			1/2		
	DANIAL ESPOSIT			ISCO	NSIN AV	E. CH	IEVY	CHASE	MAR	YLAN	ND 208	315	
	FEB 01 1995	32 REGISTRA	R'S SIGNATURE	lall.									
- 11	- 1000	11		4-4									- 1





	1	FOR STATE REGISTRAR	STATE OF I	MARYL		ARTMEN IFICAT				MENTA	L HYGIEI				
	i	1. DECEOENT'S NAME (First, Middle, Last)									OF DEATH			3. TIME OF DEA	ATH
		MICHAEL	STEP	HEN			FIE	ELDS		JAN	•	20	95	11:15	Pu
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE	(In yrs. lest birthd	//	R 1 YEAR	IF UNDER			OF BIRTH I, Day, Year)		8. BIRTH	PLACE (State or I	Foreign
9	أور	219-86-6902	1 🔀 M 2 🗌 F		_33 YR	MONTHS	DAYS	HOURS	MIN.		10,	1961		ginia	
		9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CIT	Y, TOWN	OR LOCATI	ON OF O	ATH		9c. COU	NTY OF D	EATH	
HWI	<u>.</u>	3801 KENILWORTH						BURG	3	_		PRIN	ICE C	EORGES	
(1111)	씥	10a. STATE 10b. COUNTY				CITY, TOWN		TION						10d. INSIDE CIT	
	ΑŪ·DI	Maryland Mon 100. STREET AND NUMBER	tgomery		1 60	rmant		. ZIP COD	F			T 10a CIT	IZEN OF Y	1 TYES 2 N	NO
	UNERA	21 Pickering Cour	t #01					208						States	
020 physician burial-tra	5	11. MARITAL STATUS	12. WAS DECEDEN			13.		ENOENT C	F HISPAN		? (Specify Ye		14. RACI	- American Inc	llen,
5-0020 nding physician is the burial-transit	BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES?					ecify Cube 2 🙀 NO			tican, etc.)		Spec	k, White, etc.	
	ED 8													White	
		15. DECEDENT'S EDUC (Specify only highest grade	completed)		18a. DECEDEN (Give kind life. Do NO	T'S USUAL (of work done T use retired.)	during mo		ng	16b	KIND OF BU	USINESS/IN(DUSTRY		
YLAND 21 by the hospital or be detached for u at once.	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5	+)	Arti						Self	Emplo	yed		
AN the hor detach	Š	17. FATHER'S NAME (First, Middle, Last)						18, MOT	HER'S NA		Aiddle, Maide				
YK d by t	BE	Robert Lee Field	s III					Ela	ine	Mary	Step	hens			
	စ္	19a. INFORMANT'S NAME (Type/Print)									er, City or To				
E, Ny be re sage 5	-	Robert Lee Fields	III		21 P	icker	ing	Cour	t #0	1, G	ermant				
F 6 may lector, pag	- 1	20a. METHOO OF DISPOSITION 1 □ Buriel 2 ☑ Cremation 3 □ Rem	oval from State	20b	etropol	TEOF DISPO	SITION (No	ime of	1 /	DAT	20c. L	OCATION —	-		
Age direc		4 Donation 5 Other (Specify)	ENSPEA	_ Me	etropol			ator						Virgin	ila
BALTIMORE, after death. Page 6 may be by the funeral director, page movel.		·) Ulcha	D.()	bla	4	O Ea	ast I nersb	eer ourg	Park MD	DeVol Driv 20877	e		Home	
urs after in by the removal edical (23. PART i. Enter the diseases, or of ehock, or heert feilure.	complications the	et ceused	d the death. D	o not ente	r the mo	de of dy	ing, suc	h es cerc	liec or resp	piratory an	rest,	Approxim	
filled in the on, or res		IMMEDIATE CAUSE (Final		-	out mie.									Onset an	
E € E		recuiting in deeth)			INJU										
			OUE TO	OR AS A	A CONSEQUENC	OF):									
8 . 0 .	CATION	Sequentially list conditions, if any, leading to immediate	b DUE TO	(OR AS A	CONSEQUENCE	OF):								-	
BOX ficate be ephysician to the prior to		cause. Enter UNDERLYING CAUSE (Disease or injury	C												
DS, P.O. Be the death certificate the attending physis 3 Mental Hygiene pr Injury, or other th	RTE	that initieted eventa resulting in death) LAST	DUE TO	(DR AS A	CONSEQUENCE	OF):									
	CER	resulting in death) LAST	d											-	
the deat y the atte	ا پُـ	PART ii. Other eignificent condition	a contributing to	deeth b	out not recuiti	g in the u	nderiyin	g cause (given in	Pert i.	24a. WAS A	N AUTOPSY	24b	. WERE AUTOPSY	FINDINGS
	<u> </u>									_	PERFO	RMED?		AVAILABLE PRIOR	
RECOR requires that seen signed by of Health an shows any	MEDIC										Man			DF OEATH?	NO
L R law reas been bept. of 23 sh		DID TOBACCO USE CONTI	RIBUTE TO CA	USE O	F DEATH	YES 🗆	NO [UNC	ERTAI	<u> </u>					
VITAL AN: The law tificate has e State Depi	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PLACE OF E	1									
F VIT, SICIAN: Th certificate the State t, or Iten	ŽŽ	YES 2 NO	1 🗆 Inpetient 2 (patient 3 🗆 DO	4 Nu		6 5 🗆 Re	aidenca		(Specify) 🖟				
PHYSICIAN: this certifical with the St	ᇤ	27. MANNER OF DEATH 1 Netural 5 Pending	28a. OATE OF (Month, E	Day Year)	- Carpon	INJURY		RK?	, .	28d. DES	CRIBE HOW	INJURY OC	CUREO	0.4	_
ON OF OING PHYS After this of death with s marked,	à	2 Accident Investigation	1 22	21015	/5			YES 2	NO		APPR	_	UCK	BY AU	170
ISI TTEN TTOR: after		3 Suicide 8 Could not be 4 Homicide datarmined	building.	etc. (Spec		or, etreet, tac	tory, offic	•		281. LOC City	ATION (Street or Town, State	LENN;	-WOY	TH AVE	MP
	1 5	29a. CERTIFIER (Check only	CIAN: To the best of	f my know	rledge, death occ	urred at the	Ilme, data	and place	, and due	to the cau	se(a) and ma	anner aa sta	ted.		-
TO THE HOSPITAL TO THE FUNERAL be filed within 72	COMPL	one) 2 MEDICAL EXAMINE	R: On the besis of a	xaminatio	n and/or investig	ntion, in my	opinion, d	eath occur	red at the	time, data	and place, a	and dua to th	Je Cause(I) and manner as	stated.
THE HC THE FU filed wit	w	296 SIGNATURE AND TITLE OF	00 00	1	14	1		29c. LICI	ENSE NUI	IBER				(Month, Day, Year)
5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	0 0	many	4000	1	A M	1		O.C.	M.E	•		▶ J	AN 2:	L,1995	
		30. NAME AND ADDRESS OF PERSON WHO	OJEOMPLETED CAU	W.S	1		Stre	et, l	Balt	imore	e, Mai	ryland	1 212	201	
		JAN 30 1995	32. BEGISTRA	AR'S SIGN	ex-Rardal	,									
		ישקן טע וואק וואק) juna a		IN WORK	1									

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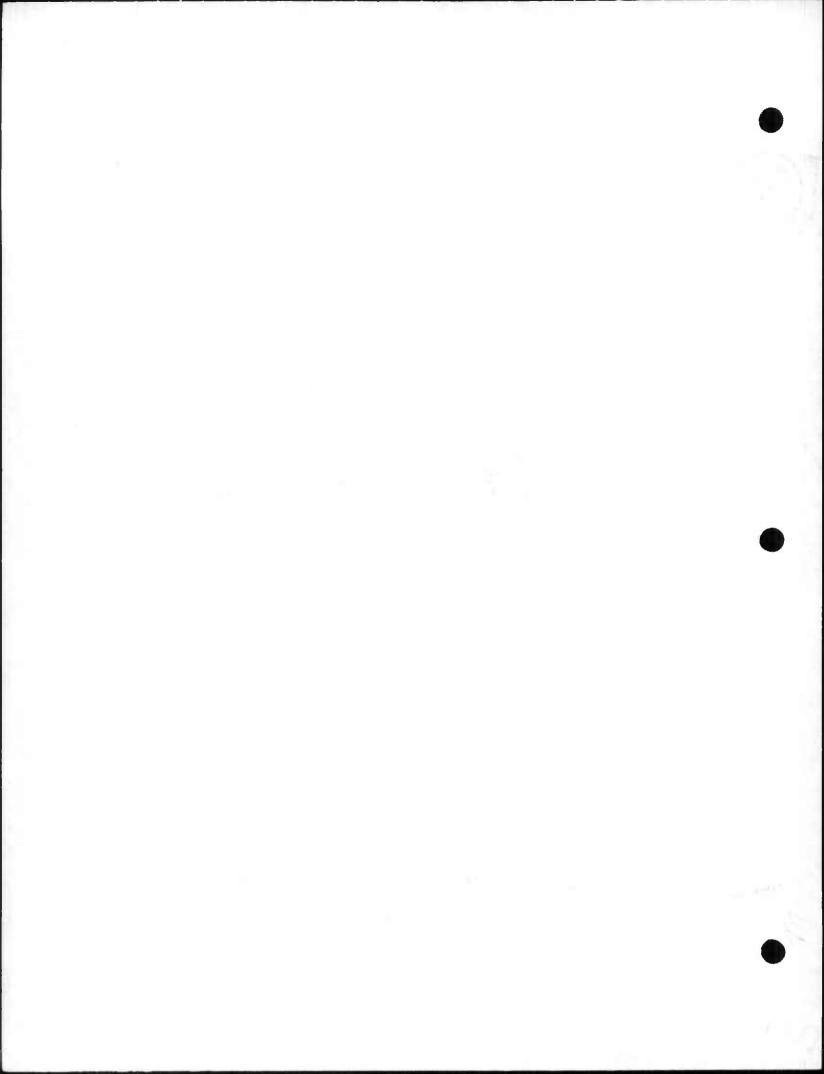
3760 BALTIMORE, MARYLAND 21215-0020	ted within 24 hours after death. Page 6 may be retained by the hospital or attending	completely filled in by the funeral director, page 5 should be detached for use as the ial, cremation, or removal.	event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trope filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	* REGISTRAR				ICATE O	DEATH		REG. NO								
	1. DECEDENT'S NAME (First, Middle, Lest)							2. DATE OF DEATH				3. TIME OF DEATH				
	Jeanine R. Fa		acey	acey							995 1:14 A M					
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER 1 YEAR		7 DATE	OF BURTH		a BIDTI	NDI ACE (Ctoto	na Cambra				
	217-96-0034	1 🗌 M 2 🔀 F	29	YRS.	MONTHS DAYS	HOURS MIN.	Jan	th, Day, Year)	1966	Wash	ningtor	D.C.				
	9a. FACILITY NAME (If not institution, give s				9b. CITY, TOWN	OR LOCATION OF D	EATH			INTY OF D		.,				
S C	Washington Adven	tist Hosp	ital		Takom	a Park				itgom						
5	RESIDENCE OF DECEDENT								1101	105011	ici y					
DIRECTOR	California Com	-			Y, TOWN OR LOC						10d. INSIDE					
۵	California San Diego			0c	eanside						1 TYES 2	₹ NO				
FUNERAL	100. STREET AND NUMBER			10f, ZIP CODE			10g. CITIZEN				WNAT COUNTR	Y7				
NA I	162 Los Padres Drive			92054						S.A.	.A.					
F	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA			IN U.S. ARMED 13. WAS DECENDENT O			NISPANIC ORIGIN? (Specify Yes or No—			14. RACI Blac	E - American k, White, atc.	Indian,				
BY				TES 1 ☐ YES 2 ☒ NO Speci						11/47/201	Specify: Black					
	15. DECEDENT'S EDUCATION		16a DE	16a DECEDENT'S LISUAL OCCUPATION			1 400	- VIND OF F	Thirtee III	DUGTO	ртас	I.				
COMPLETED	(Specify only highest grade completed)		(Gi	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUS			DUSTRY						
7	Elementery/Secondary (0-12)	College (1-4 or 5+)		Mother			Own Home									
MO	17. FATHER'S NAME (First, Middle, Last)			110		18. MOTHER'S NA	ME (First									
0	J.C. Johnson					Betty (Garridine)							
BE	19a. INFORMANT'S NAME (Type/Print)		196	. MAILING	ADDRESS (Stree	and Number or Rural			n Stele 7	n Corfe)						
임	Ian Facey					ace, Hyat					20783					
	20g, METHOD OF DISPOSITION		20b. PLACE A	ND DATE	OF DISPOSITION /	Verne of	047	TE 20c LO	CATION	City on To	own Otata					
	1 △ Burial 2 ☐ Cremation 3 ☐ Remo					relary or other pieces tonal Cemetery 1/26				6 Arlington Virginia						
	1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Aritington National Cemetery 1/26 Arlington, Virginia 22. NAME AND ADDRESS OF FACILITY Hines—Rinal di Funeral Home										.а Чото					
	> X/h/ . 10	11. 11			1180	O New Har	mpsh:	ire Ave	enue		merar	Home				
_	/ May 10/	Gurla			Silv	er Spring	g, Ma	aryland	1 20	904						
	23. PART i. Entar tha diseases, or cahock, or haart failure. i	complications that List only one caus	caused tha da se on aach lina.	ath. Dor	ot antar the m	oda of dying, suc	ch as car	diac or reapi	ratory ar	rest,	Approx	imata i Batween				
	iMMEDIATE CAUSE (Final disease or condition											and Death				
	resulting in death)	a	s Asthm													
		DUE TO (OR AS A CONSEC	UENCE OF	F):											
ON	Sequantially list conditions,	A	OB 48 4 00	Mental :												
임	if any, leading to immediate															
F			cause. Entar UNDERLYING CAUSE (Disease or injury								!					
FICATI	cause. Entar UNDERLYING CAUSE (Disease or injury	c	OR AS A COMPEO	LIENCE OF	D-			that initiated eventa DUE TO (OR AS A CONSEQUENCE OF):								
RTIFICATI	cause. Entar UNDERLYING CAUSE (Disease or injury	c	OR AS A CONSEC	UENCE OF	7):											
CERTIFICATI	cause. Entar UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DUE TO (d														
AL CERTIFICATI	cause. Entar UNDERLYING CAUSE (Disease or injury that initiated eventa	DUE TO (d				ng cause given in	Part I.	24s. WAS AN		24b.	. WERE AUTOPS					
DICAL CERTIFICATI	cause. Entar UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DUE TO (d				ng cause given in	Part I.	PERFOR	MED?	24b.	AVAILABLE PR	OT RO				
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M	cause. Entar UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DUE TO (d.s. contributing to c	death but not re	esuiting (n the underlyi			PERFOR	MED?	24b.	AVAILABLE PR	OR TO OF CAUSE				
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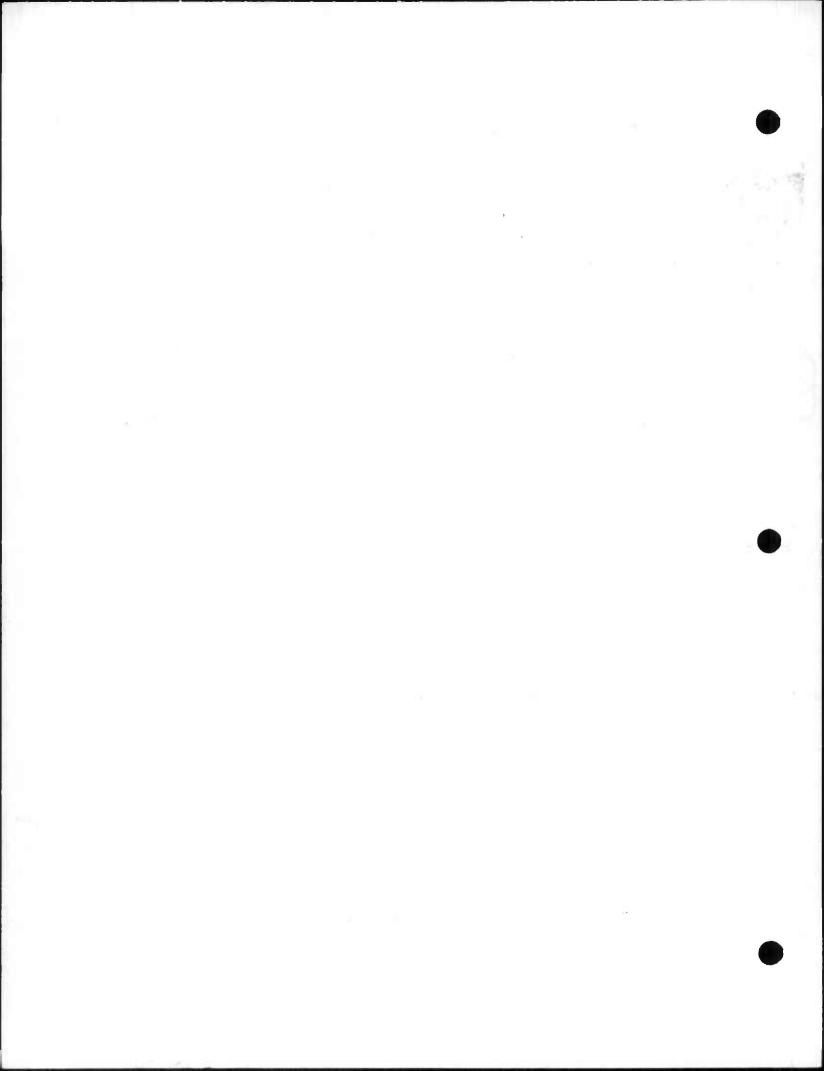
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAI	ND / DEPAR	TMENT OF I	HEALTH AND	MENTAL HYGIEN		unty.				
		Fred F	Reit	hais	BR.	2. DATE OF DEATH	9 4°	3. TIME OF DEATH				
	579-30-9148	Ø M 2 □ F 67	yrs. lest birthdey) 7 YRS.	IF UNDERLY YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year) July 20,1	927 Wa	BIRTHPLACE (State or Foreign Country) ashington D.C.				
TOR	90. FACILITY NAME (II not institution, give street Suburban Hospital RESIDENCE OF DECEDENT		96. CITY, TOWN Bethe	of DEATH Somery								
DIRECTOR	100. STATE 100. COUNTY Maryland Montgomery			, TOWN OR LOCA	ockville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO						
FUNERAL	100. STREET AND NUMBER 4107 Southend Road	1 740		f. ZIP CODE	53	10g. CITIZEN OF WHAT COUNTRY? USA						
ВҰ	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	Never Married 2 Merried FORCES? 1 N YES 2			CENDENT OF NISPA secify Cuban, Mexico 3 2 X NO Speci	e or No- 14.						
COMPLETED	(Specify only highest grade con	(Specify only highest grade completed) (Gillier Elementary/Secondary (0-12) College (1-4 or 5 +)				CEDENT'S USUAL OCCUPATION Ive kind of work done during most of working Do NOT use retired.)						
DIME	17. FATNER'S NAME (First, Middle, Lest)	I L	rector	of Hou		g Provide	ence Hospital					
	Theodore A. Freita	g										
) BE	t9e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	Emma C. Watson ODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
5	Elizabeth C. Freita	ag										
	Elizabeth C. Freitag 4107 Southend Road Rockville, Maryland 20853 200. METHOD OF DISPOSITION 1 N Burtel 2 Cremetton 3 Removal from Stata 20b. PLACE AND DATE Of DATE 20c. LOCATION - City or Town, Stata 20c. Doneston 20c. Location - City or Town, Stata 20c. Location - City or Town, Stat											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
Щ	Francis J. Collins Funeral Home, Inc. 500 University Blvd.W.Sil.Spr., MD 20901 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
	Snock, or neart isliure. List	t only one cause on each	h line.	or enter the me	rue or dying, suc	n aa cardiac or resp	iratory arrest,	interval Between				
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Ventrica DUE TO (OR AS A C	ONSEQUENCE OF	ichy con	1			3 o mil.				
NOL	Sequentially list conditions, but to (or as a consequence of): "" "" "" "" "" "" "" "" ""											
CERTIFICATION	CAUSE (Disease or injury that initiated events CAUSE (Disease or injury that initiated events											
Ë	resulting in death) LAST						M-4-4-					
A	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? AM Contributions Contributions Contributions to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? 1 yes 2 1 No											
MEC	Conjective Heart failure, Hypertoninger.							OF DEATH?				
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO NO UNCERTAIN											
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:											
1YS	1 TYES 2 NO 15	Inpatient 2 ER/Outpatie	ont 3 🗆 DOA	4 - Nursing Non		6 Other (Specily)	IN HER ACCURATE					
	Natural 5 Pending	(Month, Day, Year)	INJ	JRY WO	YES 2 NO	26d. DEŞCRIBE HOW I	D					
COMPLETED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, atc. (Specify)	At home, farm, si			28f. LOCATION (Street end Number or Rural Route Number, City or Town, Stete)						
J.E.	29e. CERTIFIER (Check only (Ch											
OM	(Check only one) 2 MEDICAL EXAMINER: On the basic of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated.											
BE	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 1-30-95 1-30-95											
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sidney J. Cohen, AD, 121 Congressional Lane, Rochick, MD 20452											
	31. DATE FILED (MONTH), Day, 1001) JAN 31 1995 Julia Sturdson Randall											

10 t



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR

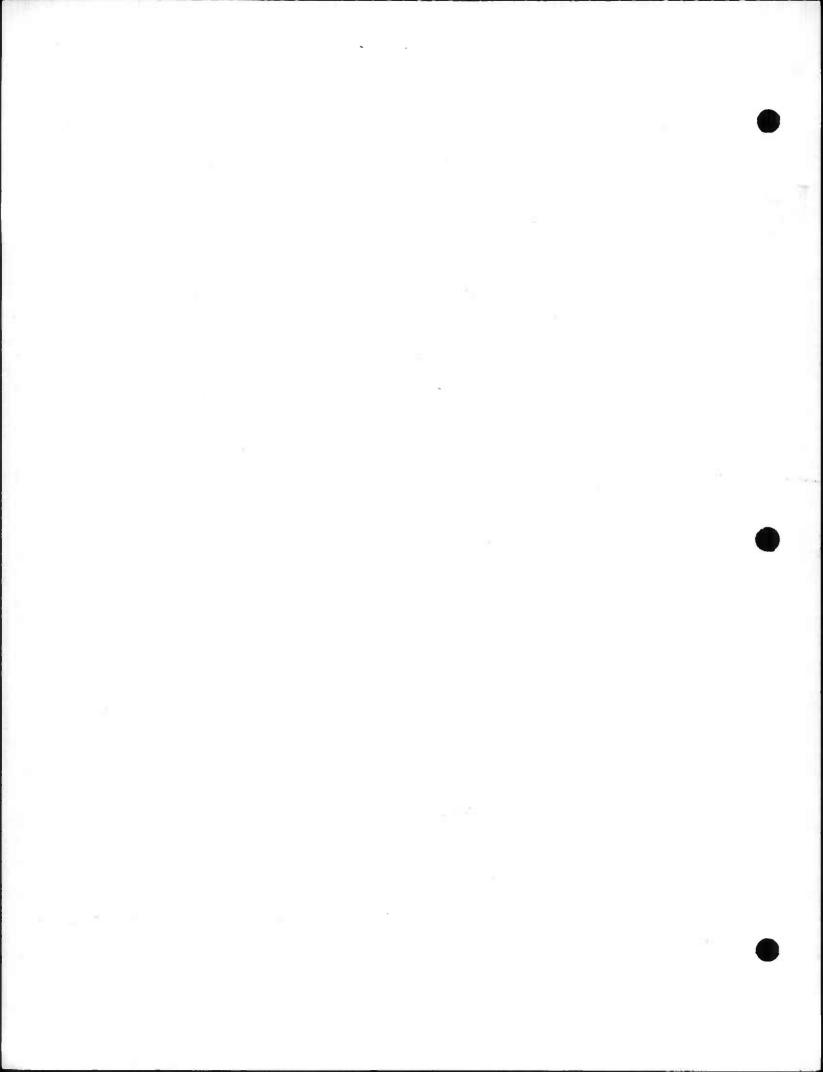
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE OF	DEATH		REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF								3. TIME OF DE	ATH				
	CARL LEE GOINS						JAN.18,1995			13:35				
	4. SOCIAL SECURITY NUMBER		E (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		<u> </u>	_	HPLACE (State or				
	243-74-6949	1 (XM 2 □ F	48 YRS.	MONTHS DAYS	HOURS MIN.	(Month, D	ay, Year)	1947	Coun	CAROL				
	9e. FACILITY NAME (If not institution, give s	treet end number)		9b. CITY, TOWN	OR LOCATION OF D				NTY OF I					
TOR	RT.313 PAST SA	NDY POINT		Sandy	Point	;			CARC	LINE				
AL DIRECTOR	_	10b. COUNTY Delaware KENT			10c. CITY, TOWN OR LOCATION Dover				10					
	10e. STREET AND NUMBER			10	10g. CITIZE			IZEN OF	EN OF WHAT COUNTRY?					
FUNERAL	507 Ross ST.			19904			U.S			5.A				
B	11. MARITAL STATUS 1 Never Merried 2/2/2/Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 15 TYPE IF YES, GIVE WAR OF	ES 2 NO	13. WAS DECENDENT OF HISPANIC ORIGIN? If yes, specify Cuben, Mexican, Puerto Ric 1 YES NO Specify:										
03	15. DECEDENT'S EDU	CATION	18e. DECEDENT'S USUAL OCCUPATION		ION	16b. KIND OF BUS		SINESS/IN	DUSTRY		_			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	He. Do NOT u	(Give kind of work done during most of working life. Do NOT use retired.)										
MP	12		Produ	Production			ndus	stri	a1					
8		17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, M					siden Surneme)			
BE	Fred Aubrey		*		Hatti									
2	190. INFORMANT'S NAME (Type/Print) Mary Goins		196. MAILING		and Number or Rural									
1	20e. METHOD OF DISPOSITION	Τ.		Ross	ST. Do									
	1 Buriel 2 Cremetion 3 Rem	Burlei 2 Cremetion 3 Removal from State												
	4 Donation 5 □ Other (Specify) Del Vet Cometery 1-23-95 Bear, Delaware. 21. SIGNATURE OF FUNERAL SERVICE 22. NAME AND ADDRESS OF FACILITY													
	Minus Funeral Home. Dover, Del.													
	22. PART I. Enter the diseases, or o	complications that caus	sed tha death. Do	not anter tha m	ode of dying, suc	h as cardisc	or reapl	ratory ar	rest,	Approxi	mate			
	shock, or heart fallura. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):													
_		DUE TO (OR A	S A CONSEQUENCE O	F): "										
<u>ó</u>	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):													
SAT	if any, leading to immediate cause. Entar UNDERLYING	•								İ				
Ĕ	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):													
	reaulting in death) LAST													
DICAL CERTIFICATION	PART II. Other aignificant condition	s contributing to death	but not resulting	In the undarlying	ng cause givan in	Part I. 24	a. WAS AN	AUTOPSV	2,41	b. WERE AUTOPSY	FINDINGS			
<u>8</u>		_			o growth		PERFORMED? AVAILABLE				OT R			
MED	11 yes :							□ NO	NO OF DEATH?					
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									NO				
ĕ	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)													
PHYSICIAN:	EXAMINER?	HOSPITAL:		OTHER:		. Von	naska T	Δ V D	TAT 7\ \	MITA				
٤I	27. MANNER OF DEATH	1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Reeldence 8 XOther (Specify) ROADWAY MVA 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED								of 1 ==				
	1 Netural 5 Pending	(Month, Day, Year	-95 130		YES 2 NO	Daver - automobile / bruss				Misin				
β	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJU		00	281. LOCATION (Street and Number or Rural Route Number,					K				
	4 Homicide determined contribute building, etc. (Specify)								Point					
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. 2 XMEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner es stated.													
ତ୍ର 🛮		end/or investigation	on, in my opinion,	death occured at the	time, date end	l place, en	d due to Il	ne cause(e) end menner e	stated.				
BE (29b. SIGNATURE AND THE GOT CERTIFIE	11/1			29c. LICENSE NUI	MBER		29d. DAT	E SIGNED	D (Month, Day, Yea	ir)			
2		Un			oc	ME	ME JAN.1			19,199	5			
_	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF	DEATH (ITEM 27) (Type	, Print)										
	NOWIN R	100 les	111 P	enn St	reet. B	altim	ore	. Ma	ryl	and 21	201			
	31. DATE FILED (Month, Day, Yber)	32. REGISTRAR'S SH	GNATURE											

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89



HELEN PREBIE GREEN Second Secondary Windows Second Secondary Windows Secondary Se			1. OECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATN		3. TIME OF DEATN		
## STORY THROUGH OF DEFECTIVE STATE OF THE S			HELEN PHEB	IE GRI	EEN							1995	4:39am M		
Secretary Secr			4. SOCIAL SECURITY NUMBER 197-12-0676	1000000			7			4.1.1.1.1.1.1.1	7 DATE OF BIRTH		8. BIRTNPLACE (State or Foreign Country)		
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THE REPORT OF STATES THE PROPERTY BOUGHTON WAS CONCERNED TO MESSAGE CONC		IRECT	10a, STATE 10b, COUNT						TION				10d. INSIDE CITY LIMITS?		
The state of the s	(WH)		10e. STREET AND NUMBER	S St.									EN OF WHAT COUNTRY?		
TO DO NOT THE PARTY OF THE PROPERTY OF THE PARTY OF THE P	0020 g physikan ne bodalasa		1 Never Married 2 Married	FORCES? 1	FORCES? 1 YES 2 NO			If yes, specify Cuben, Mexican, Puerto Ri					14. RACE — American Indian, Black, White, etc.		
The part of the pa	21 afte		15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(G	(Give kind of work done during most of working					16b. KIND OF BU				
THE NECONDARTS HAVE (Type-Price) THE NECONDARY HAVE (Type-Price) THE NECONDARY HAVE (Type-Pric	ID 2. spital o	IPLE		College (1-4 or 5 +	•)						Home	2	1		
THE PROPERTY HAVE (Fine Price) THE PRIC	AN he ho detac	ő							16. MOTH	IER'S NA					
200. METROD OF DISPOSITION Name of some pixed symbols or contributing to death but not resulting in the underlying cause given in Part I. 24a. Wes a warropsy production in the contributing to death but not resulting in the underlying cause given in Part I. 24a. Wes a warropsy production in the contributing to death but not resulting in the underlying cause given in Part I. 24a. Wes a warropsy production in the contributing to death but not resulting in the underlying cause given in Part I. 24a. Wes a warropsy production in the contributing to death but not resulting in the underlying cause given in Part I. 24a. Wes a warropsy production in the contributing to death but not resulting in the underlying cause given in Part I. 24a. Wes a warropsy production in the contributing to death but not resulting in the underlying cause given in Part I. 24a. Wes a warropsy production in the countributing to death but not resulting in the underlying cause given in Part I. 24a. Wes a warropsy production in the countributing to death but not resulting in the underlying cause given in Part I. 24a. Wes a warropsy production in the countributing to death but not resulting in the underlying cause given in Part I. 24a. Wes a warropsy production or countributing to death but not resulting in the underlying cause given in Part I. 24a. Wes a warropsy production or countributing to death but not resulting in the underlying cause given in Part I. 24a. Wes a warropsy production or countributing to death but not resulting in the underlying cause given in Part I. 24a. Wes a warropsy production or countributing to death but not resulting in the underlying cause given in Part I. 24a. Wes a warropsy production or countributing to death but not resulting in the underlying cause given in Part I. 24a. Wes a warropsy production or countributing to death but not resulting in the underlying cause given in Part I. 24a. Wes a warropsy production or countributing to death but not resulting in the underlying cause given in Part I. 24a. Wes a warropsy pr	YL by u		Rosco Blar	nkhorn											
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20 TO TO TO TO TO TO TO TO TO TO TO TO TO	LTIM th. Page neral dire					e_Me	22 1	IAME AN	IO ADDRES	S OF FA	NI ITY				
DUE TO ON AS A CONSCOURSE OF: CALLED AND AS A CONSCOURSE OF:	BA ter de the fu	Щ	1700	W.			Bo	x 2	35 (Gale	ena, MD 2	21635			
The second of th	filled in bion, or rer		IMMEDIATE CAUSE (Finel	List only one cau	se on each line	lii	1	the mo	de of dyl	ng, suci	n aa cardiec or reep	iratory arre	interval Between Onset and Death		
Sequentially list conditions, if any, leading to immediate case. Enter UNDERLYING CAUSE (Olsease or Injury Due to (or As a Conscourance of): Color	within pletel crema		reaulting in death)				,	2 cl	ne				Minutes		
CAUSE (Disease or injury that initiated events resulting in deeth) LAST CAUSE (Disease or injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): d.	execuend of purion purion	TION		DUE TO	OR AS A CONSE	DUENCE O	F):	0	luce				Weeks		
PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO MEAN TO THE YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO MEAN TO TH	00 8 80 1	IFICA	CAUSE (Disease or injury that initiated events								3		Weeks		
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NOUND NOT THE STORY OF STORY O	VIT/ STAN: The refificate in the State	YSICI	1 YES 2 NO				OTHER	-	5 K Re	sidence	6 Other (Specify)				
29e. CERTIFIER (Check only one) 29e. CERTIFIER (Check only one) 29e. SIGNATURE AND TILE OF CERTIFIER 29e. SIGNATURE AND TILE OF CERTIFIER 29e. LICENSE NUMBER 29e. LICENSE NUMBER 29e. LICENSE NUMBER 29e. LICENSE NUMBER 29e. LICENSE NUMBER 29e. LICENSE NUMBER 29e. LICENSE NUMBER 29e. LICENSE NUMBER 29e. LICENSE NUMBER 29e. LICENSE NUMBER 29e. LICENSE NUMBER	O SH SH S		1 Natural 5 Pending	26e. DATE OF (Month, De	INJURY ty, Your)	28b. TIM	URY	WOI	RK?	NO	28d. DESCRIBE NOW	NJURY OCCI	JRED		
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29c. LICENSE NUMBER 29d. DATE SIGNED (Morgh, Day, Year)	DI TAL OR TAL DIRI 72 hour	OMPLE	(Check only												
	물 물을 통	BE	A	-	A				29c. LICE	NSE NUM	BER		SIGNED (Morith, Day, Year)		

WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

MD Chesapeake Family Practi

1 - FOR STATE REGISTRAR

2

30. NAME AND ADDRESS OF PERSON

JAN 31 '95

Denitz

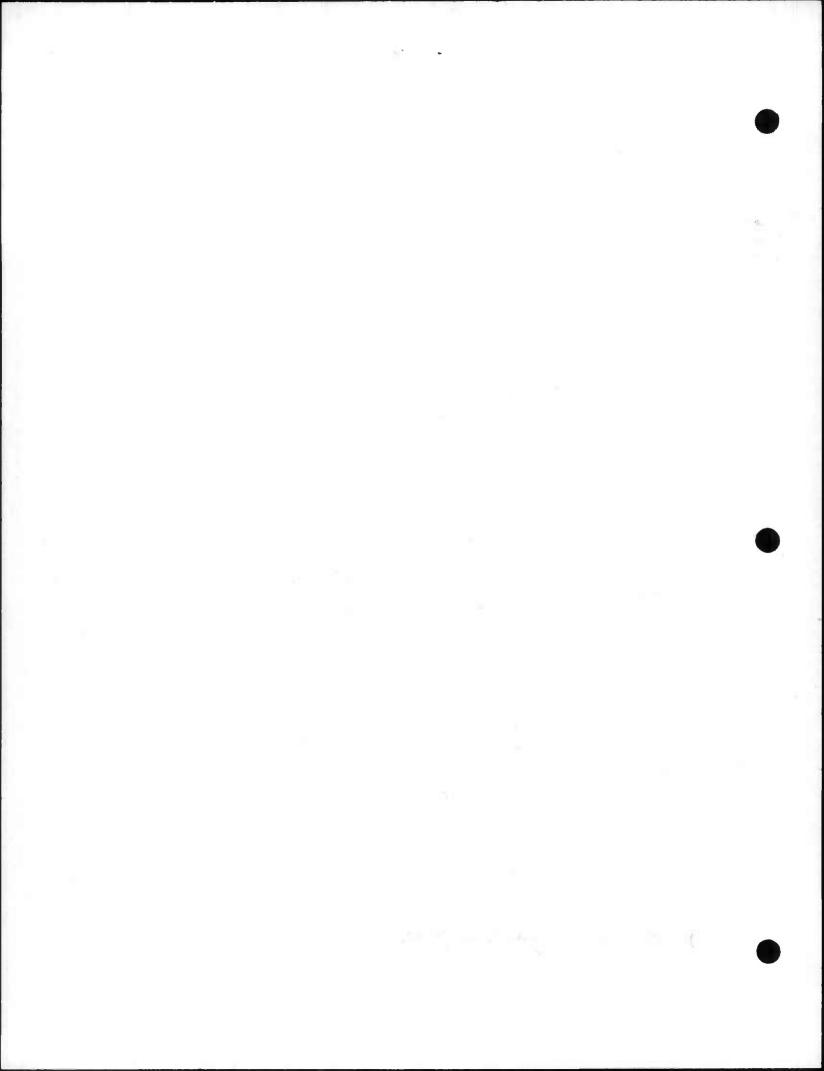
Robert

1. OECEDENT'S NAME (First, Middle, Last)

* . .

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

DHMH-16 Rev 1/89



8. BIRTHPLACE (State or Foreig

10d, INSIDE CITY

14. RACE — American Indian, Black, White, etc.

White

1 YES ZXX NO

Approximata Interval Between

Onset and Death

21. 4 orto

a 16 grees

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO

1 YES 2 NO

COMPLETION OF CAUSE

Pennsylvania

7:55

1995

Kent

32. ARGISTRAR'S SIGNATURE.

completely filled in by the rial, cremation, or removal. and corr burial, signed by the attending physician Health and Mental Hygiene prior to this certificate has been with the State Dept. of DIRECTOR: After the hours after death was HOSPITAL OR THE HOSPITAL (THE FUNERAL C filed within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: IS

Page 6 may be retained by the hospital or a mind in process

funeral director, page 5 should be detached for use as the

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event,

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any injury.

Item 23

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item

prior to 1

BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68767

DIVISION OF VITAL RECORDS, P.O. BOX 6876F BALTIMORE, MARYLAND 2	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely mied in by the funeral director, page 5 should be detached far be filed within 72 hours after death with the State Dept, of Health and Memtal Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECC	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires 1	TO THE FUNERAL DIRECTOR: After this certificate has been signe be filed within 72 hours after death with the State Dept. of Health	IMPORTANT: If item 28 is marked, or item 23 shows a

30. NAME AND ADDRESS OF PERSON WHO

31. DATE FILED (Month, Dex. Voar)

44.1. 25 1995

	FOR 1 - STATE REGISTRAR	STATE OF	MARYLAND /				EALTH .				E			
	1. DECEDENT'S NAME (First, Middle, Last)		CE	ERITE	ICATE	UF	DEAI	н	2, DATE OF	DEATH			3. TIME OF DEATH	
	Harold Ellswo	rth Gree	ne. Jr.						MONTH 1	24		5	1:30 PM	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF	BIRTH		BIRTHP	LACE (State or Foreign	
	209-20-3975	1 💢 M 2 🗆 F	66	YRS.	MONTHS	DAYS	HOURS	MIN.	9/14	728		Country)	PA	
	9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY	, TOWN C	R LOCATIO	N OF DE			9c. COUNT	Y OF DE	ATH	
OR	2779 Ocean P	ines #2 (Galley L	ane		Be	erlin				Wor	cest	er	
DIRECTOR	PESIDENCE OF DECEDENT 10a. STATE MD 10b. COUNTY	Worce	ster	10c. CIT		OR LOCATION Berlin					10d. INSIDE CITY LIMITS?			
	10e. STREET AND NUMBER	-				100	. ZIP CODE				10n CITIZE		I YES 2 X NO	
FUNERAL	2779 Ocean Pine	es #2 Ca	llov Lan					2181	1		log. Grital		SA	
S	11, MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED	13.	WAS DEC			NIC ORIGIN? (S	Specify Yee	or No- 14	L RACE	- American Indian.	
BY	1 Never Married 2 Merried 3 Wildowed 4 Divorced									Black,	white white			
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade				USUAL O		N st of working		16b. KI	ND OF BUS	INESS/INDUS	TRY		
	Elementary/Secondary (0-12)	College (1-4 or 5	+) #10.	. Do NOT u	ise retired.)						: C	al	C-	
MP		4	Col	rpor	ate r	res	ident				ing C	ara	Co.	
	17. FATHER'S NAME (First, Middle, Last)		7						ME (First, Midd	dle, Maiden	Surname)			
BE	Harold E. Gree	n, Sr.							Hilty					
2	Joanne Lind Gre	ene	191	2779	OCE	ean	Pines	or Rural is	Route Number, Galle	y La	ne Be	rlin	, MD 21811	
	20e. METHOD OF DISPOSITION 1 Buriel 2 X Cremetion 3 Rem	oval from State	20b. PLACE A			SITION (Ne	me of		DATE	20c. LO	CATION — CI	y or Tow	n, State	
H	4 Donation 6 Other (Specify)	PENINCE .	Cape	Her	nlope				/_1/25	95 I	ranki	ford	, DE	
	1. SIGNATURE OF YORKHALLERY CE LINE	Burfal					Willia		St. B				al Home 811	
	23. PART I. Enter the diseases, or o	complications the	it coused the de	ath. Do	not enter	the mo	de of dyle	ng, auc	h aa cardled	or reapl	ratory arrea	it,	Approximate	
	ahock, or heart fellure. IMMEDIATE CAUSE (Final	LIST ONLY ONE COL	use on each line). }		0		6.	. 0			1	Interval Between Onset and Death	
	disease or condition resulting in death)	mesta	stalic	un	Λο.	Con	VUA	1	In f	Mell	l (2)	0)	134 mo	
		DUE TO	(OR AS A CONSEC	OUENCE C	OF):		1	-						
N	Sequentielly list conditions,	b												
ATIC	if any, leading to immediate cause. Enter UNDERLYING	OUE TO	(OR AS A CONSEC	OUENCE C)F):									
CERTIFICATION	CAUSE (Disease or Injury	c	(OR AS A CONSEC	DIENCE O	ME).									
TE .	that initiated events resulting in death) LAST	DOE 10	(OR AS A CONSEC	WOENCE C	nrj:									
CE		d											+	
AL	PART II. Other algnificent condition	s contributing to	death but not r	reaulting	In the ur	nderiying	g cause g	iven in	Part I. 24	III. WAS AN			WERE AUTOPSY FINDINGS	
MEDICAL									1	YES 2	A red		COMPLETION OF CAUSE OF DEATH?	
ME													T YES 2 NO	
ä									- 18					
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:					ACE OF DE	ATH (Ch	eck only one)					
YSI	1 YES 2 NO		ER/Outpatient 3	□ DOA	4 Nur		o 5 XRee	eldence	6 Other (S	(pecify)				
BY PHYSICIAN:	27. MANNER OF BEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF (Month, E		26b, TIA	ME OF JURY M		URY AT RK? YES 2	28d, DEŞCRIBE HOW INJURY OCCURED						
03	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	26s. PLACE C building.	OF INJURY — At ho , atc. (Specify)	ome, farm,	street, fect	tory, office				ON (Street a fown, State)	and Number or	Rural Ro	ute Number,	
COMPLET	29e. CERTIFIER (Check only one)													
00	2 MEDICAL EXAMINE		examination and/or i	investigati	on, in my o	opinion, d	eath occurr	ed at the	time, dete an	d place, an	d due to the	cause(s)	end manner ee stated.	
BE	29b. SIGNATURINA STATE OF CERTIFIES	0 /	m				29c LICE	NSE NUI	MBER		29d. DATE	SIGNEO (Month, Day, Yeer)	
2	30, NAME AND ADDRESS OF PERSON WH	,					20	100	-0/		1/	201	7-7	

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
RNSSO 145 E,

TRASSO

DHMH-16 Rev 1/89

SAUSBURY



1	41		
	MORE, MARYLAND 21215-0020	ige 6 may be retained by the hospital or attending physician.	director, page 5 should be detached for use as the burial-transit if
	MA	retain	5 sho
	MORE, I	ge 6 may be	lirector, page

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTME CERTIFICA			MENTAI	L HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH			3. TIME OF DEATH
	Dominic Joseph	Gialluca				MONTH		W 1	FAR	
			yrs. last birthday) IF UN	ODER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	6.	BIRTHPI	11:45a M
	213-14-4012	1-2 M 2 D F	89 YRS. MONT	HS DAYS	HOURS MIN.		24-05	- 1	Country)	
	9a. FACILITY NAME (If not institution, give street	at and number)		CITY, TOWN OR	LOCATION OF D		24-03	9c. COUNTY		yland
DIRECTOR	St. Joseph's Ho				wson					more
ž l	10a. STATE 10b. COUNTY		10c. CITY, TOW	VN OR LOCATIO	ON				- 1	lod. INSIDE CITY
5	Maryland Balti	more	Tows	on.						LIMITS?
4	10e. STREET AND NUMBER	MOLC	1 10 % 3		ZIP CODE			10g. CITIZE		AT COUNTRY?
FUNERAL	1579 Dellsway				212	006		2000-1-30		
3		2. WAS DECEDENT EVER IN		13. WAS DECE	NDENT OF HISPAI		? (Specify Yes	USA	BACE -	- American Indian,
	1 Never Married 2 Married	FORCES? 1 YES	2 JNO	If yes, spec	ify Cuban, Maxica	en, Puerto F	Rican, atc.)	0, 10-	Black,	White, atc.
À	3 Widowed 4 Divorced			1 YES 2	X NO Specif	y.			Specify:	white
	15. DECEDENT'S EDUCAT (Specify only highest grade co.	FION maletarii	16a. DECEDENT'S USUAI	L OCCUPATION		16b.	KIND OF BUS	SINESS/INDUS	TRY	MILLE
<u>ا</u> ب		College (1-4 or 5+)	(Give kind of work do life. Do NOT use retire	nd.)	or working					
린	2		Supervis	or			Race	Track		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA					
BE	Dominic Gialluc	а			Unknow	m				
	19a, INFORMANT'S NAME (Type/Print)		19b. MAILING ADDR				er, Cify or Town	n, Statu, Zip Co	ode)	
2	Marcia Barranco		Same	as #	1.0					
	20s. METHOD OF DISPOSITION	20h 5	LACE AND DATE OF DISI	POSITION (Name		DATE	20c. LO	CATION — City	or Town	n, State
	1 Buriel 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	If from State cemet	ery, crematory or other ple		Com 2-	/ O F	Ca	. 1	1	1 a MD
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE			ADDRESS OF FA		1 60	CKEVS	VII	le, MD
	> Nah TE		1	Barra	nco an	d Sc	ons F	unera	1 H	ome
\dashv	22 PART I Enter the diseases or on	- Hookland that are a	- //	495 R	itchie	Hwy	. S	evern	a.P	
	23. PART I. Entar tha diseases, or con ahock, or hasrt failure. Lis	nplicationa that caused it only one cause on aec	tha daath. pe not an ch lina.	itar the mode	a of dying, auc	h ss card	lac or raspi	ratory arres	t,	Approximata Interval Between
j	IMMEDIATE CAUSE (Final disease or condition	Q	N							Onset and Death
	resulting in death) s.		pais							DAMS
		DUE TO (OR AS A C		0 -0	^					
2	Sequentially list conditions, b.	_ Ch	ione hu	nonz	Iract	to	fection	77		MONTHS
Ě	if any, leading to immediate csuse. Enter UNDERLYING	DUE TO (OR AS A C	CONSEQUENCE OF):	0	<u> </u>	4	,			
<u> </u>	CAUSE (Disease or Injury C	DUE TO (OR AS A C	Matic of	zapar	Lophy					YEMPLS
	that initiated events resulting in death) LAST	DUE TO (OR AS A C	ONSEQUENCE OF):	4 1	1 0					
CERTIFICATION	d								_	
AL	PART II. Other algnificant conditions of	contributing to death but	not resulting in the	undarlying (causa givan in	Part I	24s. WAS AN	AUTOPSY	24h. W	TERE AUTOPSY FINDINGS
U 11	1 1 0. 0	spendant Dr	Letes				PERFOR	201169	A	WAILABLE PRIOR TO OMPLETION OF CAUSE
	0.	0		clin		- 1	1 AER 3	€-wo		F DEATH?
Σ	DID TOBACCO USE CONTRIE		DEATH VECT	I NO II	LINICEDTAIN	15			1	THER S WO
PHYSICIAN:	25. WAS CASE REFERRIED TO MEDICAL		PLACE OF DEATH (Che	177 5000	UNCERTAIN	N DEC				
<u> </u>	EXAMINER?	OSPITAL:	OTH	ER:						
≝ II	27. MANNER OF DEATH	28s. DATE OF INJURY	28b. TIME OF	Nursing Home 38c, INJUR	5 Residence					
	Natural 5 Pending	(Monto Dec Year)	INJURY	WORK	B 2 □ NO	and Dep	CRIBE HOW II	GUNT OCCUR	ED	- 1
à I	2 Accident Investigation 3 Suicide 6 Could not be	28s. PLACE OF INJURY -	At home from street 1		s 2 L. 1 NO	781 / 004	TION (Press)			
	4 Homicide 6 Could not be determined	building, etc. (Specify	9	Street, Gines		City o	TION (Street a or Town, State)	ntr Asympter or s	ON HOW	TE MUNICIPAL
MPLET	29a. CERTIFIER				_				_	
<u> </u>	(Check only	N: To the best of my knowled								
5	2 MEDICAL EXAMINER:	On the basis of examination a	and/or investigation, in m	ty opinton, dear	th occured at the	time, data	and place, and	due to the c	euse(e) =	nd manner as stated.
H H	296. SIGNATURE AND TITLE OF CERTIFIER			2	9c. LICENSE NUN	MBER		29d. DATE Ş	GNED (M	fonth, Day, Year)
	- Jak				MOY	1130	11	▶ 3	3/2	2
=	30. NAME AND ADDRESS OF PERSON WHO O	OMPLETED CAUSE OF DEAT	H (ITEM 27) (Type, Print)				1	,		
		TTER, MD.	, ST	1926	eph Ho	spita		tous	on	· mo
	31. DATE FILED (Month, Day 39)5	32. REGISTRAR'S SIGNAT								
- 1	1h	La managale was	dall							

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTII

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY FUNERAL DIRECTOR TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Thours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-train be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

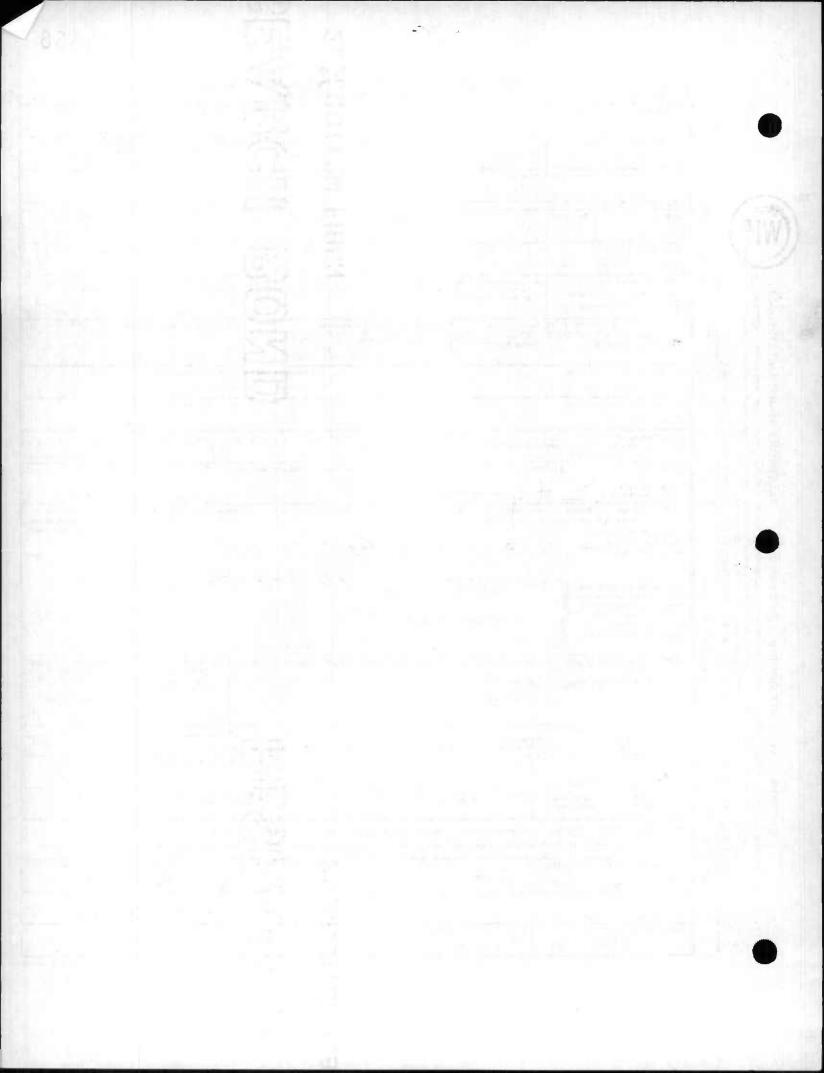
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - STATE REGISTRAR	STATE OF MARY	AND / DEPARTM CERTIFIC			MENTAL HYGIE					
DECEDENT'S NAME (First, Middle, L Mildred 4. SOCIAL SECURITY NUMBER	Lee	Garvey			2. DATE OF DEATH MONTH February	6, 199				
578-18-9938 9a. FACILITY NAME (If not institution, g	1□M27€ 73	YRS. MO	UNDER 1 YEAR HITHS DAYS	HOURS MIN.	July 10,	1921 W	BIRTHPLACE (State or Foreign Country), AShington, D. Y OF DEATH			
9640 J Barrel H	louse Road		Laure	1		Howa				
Maryland Ho	oward	La	urel	ZIP CODE		10- CITIZE	LIMITS? 1 YES 2 NO N OF WHAT COUNTRY?			
9640 J Barrel Ho				20723-1		U.S	S.A.			
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	2 (\(\super \text{ND}\)	If yes, spe	NDENT OF HISPA city Cuban, Mexic 2 (S) NO Special	NIC ORIGIN? (Specify an, Puerto Rican, etc.) fy:	Yes or No- 14	t. RACE — American Indian, Black, White, etc. Specify: Willite			
15. DECEDENT'S (Specify only highest of Specify only highest of Specify only highest of Specify only highest of Specify Only 12	EDUCATION rade completed) College (1-4 or 5+)	16a. DECEDENT'S USI Give kind of work life. Do NOT use re Adminis	done during mos etired.)	t of working		U.S. Governmen				
17. FATHER'S NAME (First, Middle, Last, Carey Hawkins				ALICE	AME (First, Middle, Melo Frownfelt	len Sumame) CT				
Valerie Tyra					Road Lau					
20e. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 1 4 Donation 5 Other (Specify)	Removal from State CO	b.PLACE AND DATE OF D		ne of			y or Town, State lle, Maryland			
PI. BIGNATURE OF FUNERAL BEIDGE	LICENSEE		Donal	dson Fu Calbott	ineral Hon Avenue I	e P.A. aurel,	Md. 20707			
23. PART I. Enter the diseases, ahock, acheert failt immediate CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events rasulting in death) LAST	s. ONGLS DUE TO (OR AS DUE TO (OR AS	each line.	,		aire vior		t, Approximate Interval Between Onset and Dea			
PART II. Other significant condi	tions contributing to death	but not resulting in t	he underlying	cause given in	PERF	AN AUTOPSY CORMED? 2 NO	24b. WERE AUTOPSY FINDING AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES: 2 NO			
25. WAS CASE REFERRED TO MEDICA	HOSPITAL:	10	26. PL/	NCE OF DEATH (C)	heck only one)		1			
1 VES 2 NO 27. MANNER OF DEATH	1 □ Inpatient 2 □ ER/Out 25e. DATE OF INJURY	patient 3 DOA 4	Nursing Home	RY AT	8 Other (Specify) 28d. DESCRIBE HO	W INJURY OCCU	RED			
1 Natural 5 Pending 2 Accident Investigat		INJŪRY	M 1 Y	ES 2 ND						
3 Suicide 6 Could not 4 Homicide determine	building, atc. (Spe	Y — At home, farm, stree lolly)	et, factory, office		28f. LOCATION (Stre City or Town, Str		Rural Ploute Number,			
0.0-1	HYSICIAN: To the best of my know									
29b. SIGNATURE AND TITLE OF CERT	FIER 131 X			29c. LICENSE NU	MBER	29d. DATE S	BIGNED (Month, Dey, Year)			
30. NAME AND ADDRESS OF PERSON		EATH (ITEM 27) (Type, Pri	ne) /	, (1)	7 11		36/201			
31. DATE FILED (Month, Day, Year) FEB 0 7 10	32. REGISTRAR'S SIGN	NATURE)	lathe	vill	e Mi	1 a	078/			

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tate Dept. of Health and Mental Hygiene prior to burials cremation, or removal.	avaminar
or remova	nadiesi
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prior to	fraum
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Dept	23
tate	tem

												04001
	1 - FOR STATE REGISTRAR	STATE OF N		DEPAR					MENTAL HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATH
	Dessie.	Garr	ett						Feb 2	AY C	YEAR	U 15
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	st birthday)	IF UNDER	R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH		1	LACE (State or Foreign
	224 - 30 - 8554	1 M 2 🔏 F	76	YRS.	MONTHS	DAYS	HOURS	MIN.	Feb 18, 1	918	Country)	ginia
	Se. FACILITY NAME (If not institution, give s	treet end number)			9b. CITY	(TOWN O	R LOCATIO	ON OF DE			NTY OF DEA	
Œ	Laurel Regional H				Lau		n Eocalio	ON OF DE	SAIR			
18	RESIDENCE OF DECEDENT	OSPICAL			Lau	гет		_		Pri	nce G	eorge
DIRECTOR	10e. STATE 10b. COUNTY	r		10c. CIT	Y, TOWN	OR LOCATI	ION				1	IOd. INSIDE CITY
<u>a</u>	Maryland Princ	e George		Lau	rel							LIMITS?
¥	10e. STREET AND NUMBER					101.	ZIP CODE			10g. CITI	ZEN OF WH	AT COUNTRY?
FUNERAL	41 B Street					2	0707			US	Δ	
15	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED	13.	WAS DECE	ENDENT O	F HISPAN	IIC ORIGIN? (Specify Yes	-	14. BACE -	- American Indian,
	1 Never Married 2 Married	FORCES? 1	YES 2 X	NO			city Cuber 2 [X] NO		n, Puerto Ricen, etc.)		Black, Specify:	White, etc.
ВУ	3 Wildowed 4 X Divorced						E 22 110	ороспу			W	hite
9	15. DECEDENT'S EDU- (Specify only highest grade	CATION completed)	16e. DE	CEDENT'S	USUAL O	CCUPATIO	N of all working	_	16b. KIND OF BU	SINESS/IND	USTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5 +		. Do NOT us	e retired.)	during mos	i ur worning	v				
4	unknown		Lat	ındre	SS				Towel S	Supply	y Com	pany
COMPLET	17. FATHER'S NAME (First, Middle, Last)						16. MOTH	IER'S NA	ME (First, Middle, Maiden			
BE	Joe Anderson						Bess	sie	Lee Sprous	se		
TO E	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRES	S (Street er	nd Number	or Rural F	Route Number, City or Tow	n, State, Zip	Code)	
-	Bessie Salsburg 207 South Bentlou, Baltimore, Maryland 21223											
	20e. METHOD OF DISPOSITION 1 🔀 Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of camelery, cremetory or other place)											
	4 Donation 5 Other (Specify)		Ivy H	ill (emet	erv			2/6 Lau	rel,	Maryl	and
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
	* Will Hand	4/1/	-						eral Home,			
	23. PART I. Enter the diseases, or o	complications that	coused the de	eth Do r	ot enter	the mos	aTpot	tt A	ve. Laurel	, Mai	ylan	
	anock, or neart tailure.	Liet only one ceu	se on eech line).	or onter	the mot	ie bi dyn	ng, sucr	i ea cerulec or reap	ratory arr	wat,	Approximeta Interval Batween
	IMMEDIATE CAUSE (Finel disease or condition		~	0 6								Onset and Death
	resulting in death)	e	OR AS A CONSE	OUENCE OF	70							
-	_	552.10	< 0410	DUE O	7.	P	G 44	(10	tohoai			
₫	Sequentially list conditions,	DUE TO	OR AS A CONSE	DUENCE OF			WY	7	10 12000	9		
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING		M	ula	0	16	001	5	topeni			
트	CAUSE (Disease or injury that initiated events	DUE TO	OR AS A CONSE	DUENCE OF	7: 7	217/	_0/3(<u> </u>	+
E	resulting in death) LAST			•	•	1						
"												<u> </u>
4	PART II. Other aignificent condition	a contributing to	deeth but not r	Phitiuse	n the ur	nderlying	ceuse gi	iven in	Part I. 24s. WAS AN PERFOR	AUTOPSY MED?		YERE AUTOPSY FINDINGS
MEDICAL	arrenic	UNIN	ichre	3	ul	ma	nay	Ses	lay 1 - YES 2	_	C	OMPLETION OF CAUSE
뿔		Gastr	Mis				1		1	(YES 2 SONO
ä	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DEA	TH YE	S 🔲 I	NO 🗆	UNCE	ERTAIN	1 🗆			
8	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLAC	E OF DEAT								
Sic	1 VES 2 NO	HOSPITAL:	ER/Outpetient 3	□ DOA	OTHER 4 Nun		5 Res	eldence	6 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	26e. DATE OF (Month, Da	INJURY N. Vent	20b. TIM		20c. INJU WOR	RY AT	T	2ed. DESCRIBE HOW II	NJURY OCC	URED	
BY F	1 Natural 6 Pending 2 Accident Investigation	(monn, or	rour)	INJ	M		ES 2	NO				
	3 Suicide 6 Could not be	26e. PLACE OF	INJURY — At ho	me, ferm, s	treet, fect	ory, office			201. LOCATION (Street e	and Number	or Rural Rou	ite Number,
I W I	4 Homicide determined	ounding,	are (opecity)					- 1	City or Town, State)			
121	29e. CERTIFIER 1 Check only	CIAN: To the best of	my knowledge, de	ath occurre	d at the t	lme, date e	and place	and due	to the cause(s) and man	ner ee elete	ed.	
COMPLET	(Check only one) 2 MEDICAL EXAMINE											nd menner ee stated.
	29b. SIONATURE AND TITLE OF CERTIFIE	-					€9c. LICEN					
W I				A 1	1		S. LICE) (71	ZVG. DATE	1 2	fonth, Day. Year)
O B					1		- 1.3	OK Y	121	P 20	-1 -31	1 -

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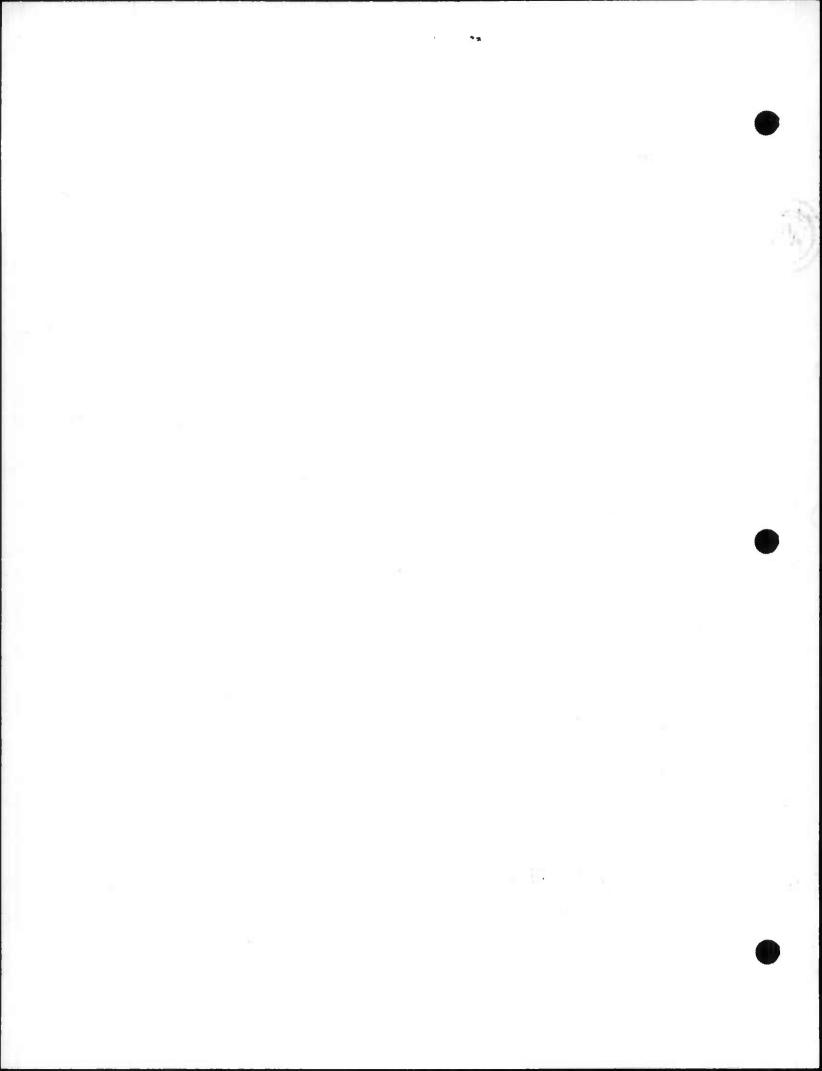
WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Palent)

32 TREGISTRAP'S SIGNATURE
July Davisor Pardall

30. NAME AND ADDRESS OF PERSON WHO CON

31. DATE FILED (Month, Day, Year)

207 0



BALTIMORE, MARYLAND 21215-0020	thours after death. Page 6 may be retained by the hospital or attending physician.	lled in by the funeral director, page 5 should be detached for use as the burial-transit n, or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the bospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

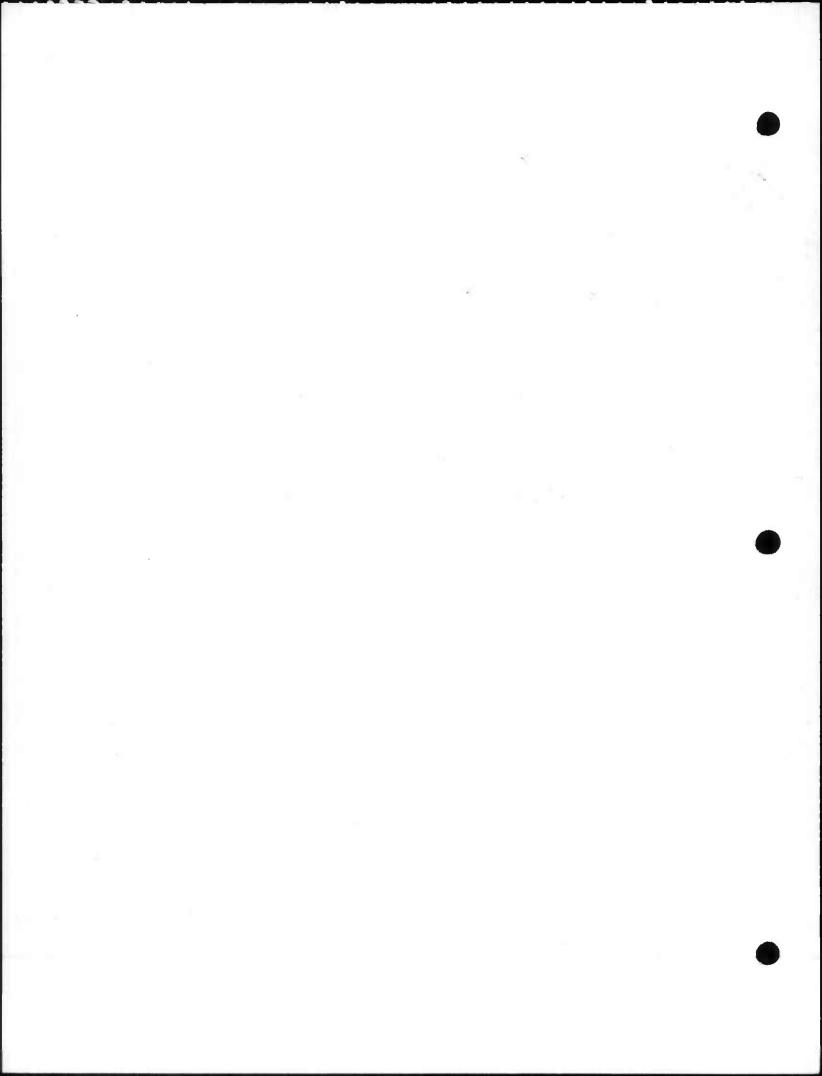
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR		STATE OF MARY				HEALTH AND	MENT	AL HYGIEN				
1. DECEDENT'S NAME (First	t, Middle, Last)						2. DAT	E OF DEATH		1 3	. TIME OF DEATN	
CHARLES 4. SOCIAL SECURITY NUMBER					_		Feb		995	YEAR	1915	М
217-18-870			iE (in yrs. ie: 7 1		IF UNDER 1 YES		7. DAT (Mor Sep	e OF BIRTH	1923	Couptry) Mar	ACE (State or Foreign	n
9a. FACILITY NAME (If not in	nstitution, give str	eet and number)			9b. CITY, TOV	VN OR LOCATION OF D			9c. COUNT			
Frederick	Memor	ial Hospita	1		Fre	derick			Fre	ederi	lck	
10e. STATE	10b. COUNTY			10c. CITY,	TOWN OR LO	CATION				1	0d. INSIDE CITY	-
Maryland	Fr	ederick			Thurmo	ont					LIMITS?	
10e. STREET AND NUMBER				-		101. ZIP CODE			10g. CITIZE		AT COUNTRY?	_
11220 Hes	song B	ridge Road				21788			Unite	ed St	ates	
11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo	Merried	12. WAS DECEDENT EYER FORCES? 1 YE IF YES, GIVE WAR OR WWII	R IN U.S. AF	RMED	If yes	DECENDENT OF HISPA , specify Cuben, Mexic YES 2 NO Speci	an, Puerto		or No — 1	4. RACE - Black, 1 Specify:	- American Indien, White, etc.	
	EDENT'S EDUC			CEDENT'S U			16	Sb. KIND OF BU	SINESS/INDU	STRY	***************************************	
Elementery/Secondary (C	1	College (1-4 or 5 +)	life	. Do NOT use	retired.)	most of working						
		2	Pe	rsonel	Mana	ger		Elec	tricia	1		
17. FATHER'S NAME (First, M	0.0%					18. MOTHER'S N	AME (First,	, Middle, Maiden	Sumame)			
George Wi		Green				Lavina						
19e, INFORMANT'S NAME (7						et and Number or Rural			n, State, Zip C	(ode)		
Ruth Shaff				11220	Hesso	ng Bridge	Roa	d Thu	rmont,	, MD	21788	
20e. METNOD OF DISPOSIT 1 Buriel 2 Cremetic 4 Donation 5 Other	on 3 🗆 Remo		amotoni ori	and date of matory or other haven	andone!	_' ial Garde	1		cation — ci			an
21. SIGNATURE OF FUNERA	L SERVICE LICE	NSEE	11000	114 7 011	22. NAM	E AND ADDRESS OF FA	ACILITY C	+ee-	TICC	10110	Harry T	·an
Vann	, R.	Savage	7		1621	Opossumt	own	Pike	Freder	cick,	MD 217	702
23. PART i. Enter the d shock, or h IMMEDIATE CAUSE (Fir disease or condition	aart fallure. L	iat only one dadse on	aach line	t.		mode of dying, sur			retory street	nt,	Approximate interval Betw Onset and Da	
reaulting in death)	→ a	DUE TO (OR AS	S A CONSE	OUENCE OF	1	Jan 1	reve					
Sequentially list condit		DUE TO (OR AS	A.S	OUENCE OF:	/							
If sny, lesding to imme csuse. Enter UNDERLY	ING										į	
CAUSE (Diseasa or Inju that initiated evants resulting in death) LAS		DUE TO (OR AS	A CONSE	OUENCE OF):								
PART II. Other significa	nt conditions	contributing to death	but not	marrielma Im	After complete	de a como de la de	D. a.l.	I				
TANT III OTHER SIGNIFICA	N7 D	1) 1	- Dut not i	esulting in	the undari	ying cause givan in	Part I.	24a. WAS AN PERFOR	MED?	A	TERE AUTOPSY FINDING WAILABLE PRIOR TO OMPLETION OF CAUS F DEATH?	-
											YES 2 NO	
		IBUTE TO CAUSE	OF DEA	TH YES	□ NO	☐ UNCERTAI	Ν□					
25. WAS CASE REFERRED TO EXAMINER?	-	HOSPITAL:	26. PLAC	E OF DEATN	(Check only o	ne)						
1 TYES 2 THO		1 Inpetient 2 ER/O		® boa 4	☐ Nursing I	fome 5 - Reeldence	7					
	Pending Investigation	28a. DATE OF INJUR (Month, Day, Year		28b. TIME INJUI	PY.	INJURY AT WORK? YES 2 NO	28d. DE	EŞCRIBE HOW I	NJURY OCCU	RED		
3 Suicide 8	Could not be determined	28e. PLACE OF INJU building, etc. (S)	RY — At ho	me, ferm, str	eet, fectory, c	ffice		CATION (Street a y or Town, State)		Rurel Rou	te Number,	
		IAN: To the best of my kno									nd menner ee state	d.
29b. SIGNATURE AND TITLE		1111	/			29c. LICENSE NU		- V.VI.) 1			fonth, Day, Year)	
	_	M	140			D-17	54	9	10	2/0	~ 0 =	
30. NAME AND ADDRESS OF William F.	Harp	er, M.D.	DEATN (ITE	M 27) (Type, P	So. (enter 5	t.	Th	urm	mt.	Md.21	785
31. DATE FILED (Month, Day,	1995	32. REGISTRAN'S SIE	GNATURE M-Rand									

DHMN-16 Rev 1/89



TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR		STATE OF I	MARYL	AND / CE	DEPART	MENT OF	HEALTH	AND I	MENT/	AL HYGIEN	E			
1. DECEDENT'S NAME (First,	, Middle, Last)	WILLIE	TDA						2. DAT MON	E OF DEATH		YEAR 95	3. TIME OF DEAT	
4. SOCIAL SECURITY NUMBER	NFR .	5. SEX		In yrs. lasi		IF UNDER 1 YEA		R 24 HRS.	~	E OF BIRTH	/		10:43	Рм
215-44-2986		1 X M 2 - F	o. AGE	49		ONTHS DAY		MIN.	(Mor	2/1945		Count	BIRTHPLACE (State or Foreign Country) Virginia	
9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9	b. CITY, TOW	N OR LOCAT	ON OF DE	_		9c. COU	COUNTY OF DEATH		
Frederick		ial Hospi	tal			Frede	rick				Fre	der	ick	
RESIDENCE OF DEC	10b. COUNT	Υ			10c CITY	TOWN OR LO	CATION						104 BIRIDE OUT	
Maryland	Frede	erick				deric					10d. INSIDE CITY LIMITS? 1 YES 2 X NO			
10e. STREET AND NUMBER							10f, ZIP COD	E			10g. CITI	ZEN OF 1	WHAT COUNTRY?	
5702H Laven	der Pl	laza				- 1	2170	01				U.S.	Α.	- 1
11. MARITAL STATUS		12. WAS DECEDEN	T EVER II	V U.S. ARI	MED	13. WAS	DECENDENT (OF HISPAN	IIC ORIG	IN? (Specify Yea	or No-	14. RAC	E — American Indi	en,
1 Never Married 2		FORCES? 1 IF YES, GIVE V	YES	2 [X]N ATES	0	If yes	specify Cube	m, Maxica Specify	n, Puarto	Ricen, etc.)		Spec	k, Whita, atc.	
3 Widowed 4 Divo	bean							,,,,,,				Opos	White	
(Specify only	EDENT'S EDU	completed)		(Gi	CEDENT'S US we kind of wor Do NOT use	SUAL OCCUP	ATION most of worki	ng	16	b. KIND OF BUS	SINESS/IND	USTRY		
Elementary/Secondary (0-12) College (1-4 or 5+) Cabinet Top Laminator None														
17. FATHER'S NAME (First, M	liddle, Last)					207 2				Middle, Maiden	Sumame)			
John W. Gar	rison						Etl	nel N	1. II	nknown	,			
19a. INFORMANT'S NAME (7	ype/Print)			196	. MAILING A	DDRESS (Stre			-	mber, City or Town	n, State, Zip	Code)		
Rose M. Gar	rison			5	702Н	Laven	der P	laza	Fre	derick	Mar	y1ar	nd 21701	
20a. METHOD OF DISPOSITE 1 X Burlel 2 ☐ Cremetic		oval from Stata	com	. PLACE A	ND DATE OF	DISPOSITION	(Name of		DA	TE 20c, LO	CATION —	City or To	own, Stata	
4 Donation 5 Other	(Specify)		Re	stha	ven M	lemori	al Gar	rdens	3 2/	11 Fre	ederi	ck,	Marylan	d
21. SIGNATURE OF PUNESA	La	mile	9	5		ROBE		DAII	LEY				HOMES, P	
23. PART Enter the di	iseases, or	complications the	t crused	the de	eth. Do not	enter the	mode of dy	ing, eucl	h ea ce	SI. FI	ratory arr	eet,	MD 217	
IMMEDIATE CAUSE (Fin		List only one cau	on e	ach ilne									Onset and	Death
disease or condition resulting in deeth)	→	. [nd	77	Cale	Lv.	J. Y	1800	**	due t	06	ati.	: Fibros	21
Todating in death,		DUE TO	(OR AS A	CONSEC	UENCE OF):		, 1							`
Sequentially liet conditi	lona,	b. DUE TO	(OR AS A	CONSEC	UENCE OF):							_		
if any, leading to imme- cause. Enter UNDERLY		502 10	(OR AS A	COMSEC	DENCE OF):									
CAUSE (Diseese or injuthat initieted events	iry	c. DUE TO	(OR AS A	CONSEC	UENCE OF):						-		- 	
reauiting in death) LAS	T	a -												- 4
		d												
PART II. Other algnifice	ent condition	e contributing to	death b	ut not re	esuiting in	the underly	ying cause	given in	Part i.	24a. WAS AN PERFOR		246	. WERE AUTOPSY FI AMILABLE PRIOR COMPLETION OF C	10
										1 TYES 2	NO		OF DEATH?	2036
DID TOBACCO U	SE CONT	RIBLITE TO CA	LISE O	E DEA	TH VES	M NO		ERTAIN					1 TYES 2 1	40
25. WAS CASE REFERRED TO		NIBOIL TO CA			_	(Check only o		LKIAII	<u> </u>					
EXAMINER? 1 YES 2 NO		NOSPITAL:	ER/Outp	etlent 3		THER:	fome 5 🗆 R	esidence	6 Oth	er (Specify)				
27. MANNER OF DEATH		28a. DATE OF (Month, D			28b. TIME (OF 28c.	INJURY AT WORK?		28d. DE	SCRIBE HOW II	JURY OCC	URED		
	Pending investigation				111111		YES 2] NO						
	Could not be determined	28e. PLACE O building,	F INJURY etc. (Spec	— At hor	ne, farm, stre	net, factory, o	ffica			CATION (Street a y or Town, State)	nd Number	or Rural i	Route Number,	
29a, CERTIFIER						-								
(Check only		CIAN: To the best of R: On the basis of a											n) and manner as a	tated.
29b. SIGNATURE AND TITLE							1							
One And Title	XX	T.					and the same	ENSE NUM					(Month, Day, Year)	

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

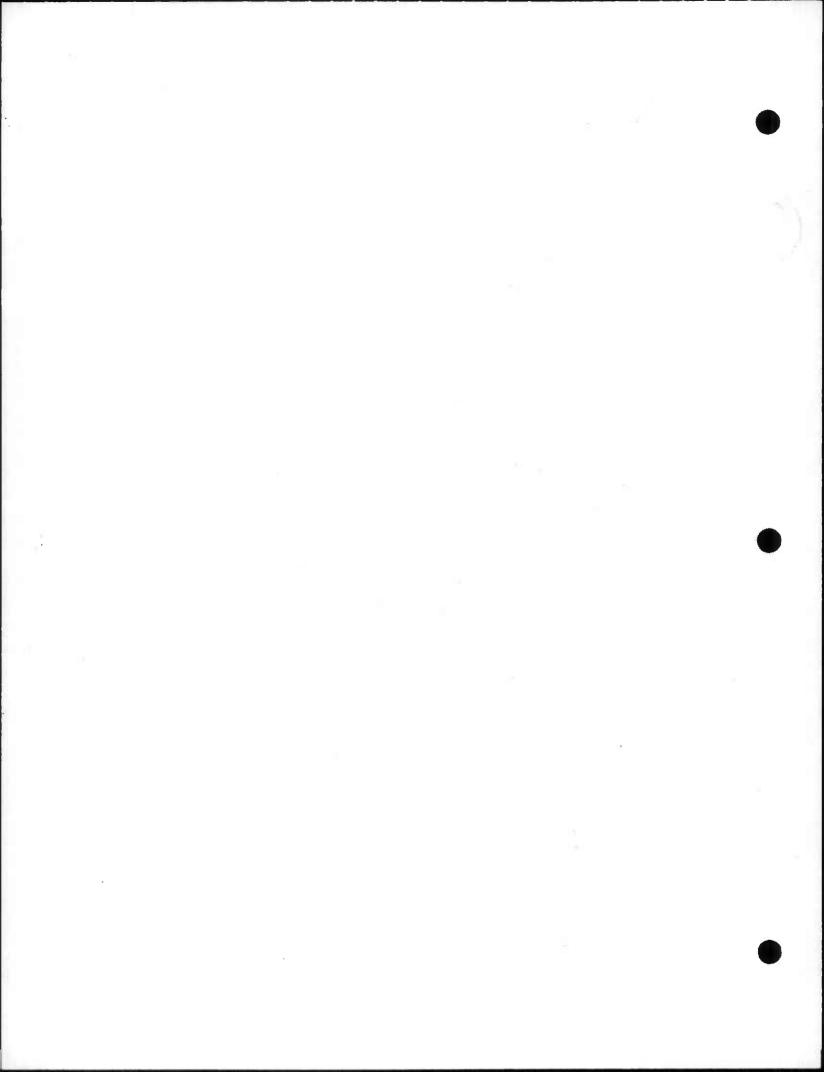
WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

2. GTiTtom AVC Jone 5
31. DATE FILED (Month, Day,
FEB 1 JU, to 204 32. REGISTRAR'S SIGNATURE Randall

Year) 1995

BALTIMORE, MARYLAND 21215-0	in 24 hours after death. Page 6 may be retained by the hospital or attending	ely filled in by the funeral director, page 5 should be detached for use as the nation, or removal.	, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filed within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI	MENT OF H	EALTH AND	MENTAL HYGIEN			
1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
1	WILLIAM FA	REDERICK	6	RAFFA	AN JR.	FEBRUARY	01 19	AR 1940 PM	
1	4. SOCIAL SECURITY NUMBER 5	6. SEX 6. AGE (III		F UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BIRTH	Lai	BIRTHPLACE (State or Foreign	
		X⊒Xw 2 □ F 65	YRS.	ONTHS DAYS	HOURS MIN.	Dec. 15, 1	929	New York	
~	9a. FACILITY NAME (If not institution, give stree		9		R LOCATION OF D		9c. COUNTY		
DIRECTOR	Shady Grove Adv	entist Hos	spital	Kock.	ville		Mont	gomery	
EC	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10d, INSIDE CITY	
DIF	Maryland Monte	gomery	Gai	thers	burg			LIMITS?	
AL	104. STREET AND NUMBER			10f	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
FUNERAL	33 Goshen	Court			2088	32	Ame	rican	
FU	11. MARITAL STATUS 12 1 Never Married 2 Married	2. WAS DECEDENT EVER IN FORCES? 1- YES	2 NO	13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	s or No- 14.	RACE — American Indian, Black, White, stc.	
ВУ	3 Wildowed 4- Divorced	Army - 19	48		2 NO Specif			Specify: White	
	15. DECEDENT'S EDUCAT	ION I	16a. DECEDENT'S US	UAL OCCUPATIO	DN .	16b. KIND OF BU	SINESS/INDUST	BV	
E	(Specify only highest grade con Elementary/Secondary (0-12)	mpleted) College (1-4 or 5+)	(Give kind of world). Do NOT use it	k done during mo	st of working	1000 1000	311.233/11.0331		
MPL	12		Executi	ve Che	ef	Rest	auran	t	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden			
B	William Freder	cick Graff			L	Veronic			
9	19a. INFORMANT'S NAME (Type/Print) Kelly J. Steiche	⊃n	19b. MAILING AL	OCHON	COLLY +	Route Number, City or Tow	n. State, Zip Coo	20882 Maryland	
	20a. METHOD QE DISPOSITION		PLACE AND DATE OF						
	1 Buriel 2 Cremation 3 Remova	I from State	tery, cramatory or other	place) Crer	matoriu	0ATE 20c. LO	theed:	a, Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE 1			D ADDRESS OF FA		oncida	a, Haryrana	
	> Town I	Valleaner	/					Funeral Home	
	23. PART i./Enter the diseases, or com	polications that coused	the death. Do not	12640	Ridge	Road, Da	mascus	S, Maryland Approximata	
	23. PART I./Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on asch line.								
1	IMMEDIATE CAUSE (Fine) disease or condition C31 MUMBURL								
	resulting in death) 8	DUE TO (OR AS A	CONSEQUENCE OF):	,	t _e			27 way	
z	b.	Pulmonar	4 Kufls	Hensy	のス			Days	
E	Sequentielly list conditions, if any, leading to immediate	O DUE TO JOH AS A	ONSEQUENCE OF):	0	1.0.	0 0.	max.	Λ	
5	cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A	LOCULATION OF	ny del	reis	Syndros	ne	Days	
CERTIFICATION	that initiated events resulting in death) LAST	DOL TO (ON AS A C	COMPEODENCE OF):	,		,			
	d,_								
AL	PART II. Other algnificent conditions c	ontributing to death bu	t not reaulting in t	the underlying	cause given in	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
ă	uny waces. The	umonech	my			1 YES 2	XNO	COMPLETION DF CAUSE OF DEATH?	
×	DID TODA CCO LICE CONTRIB			À-/				1 TYES 2 NO	
AN	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL		B. PLACE OF DEATH	MO □	UNCERTAIN	1 🗆 📗			
PHYSICIAN: MEDIC	EXAMINER?	OSPITAL:		THER:					
¥	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME C			8 Other (Specify) 28d. DESCRIBE HOW I	N.HJBY OCCUBE	0	
ВУ Р	1 Natural 5 Pending	(Month, Day, Year)	INJUR	WOI 1 Y	RK?				
	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY - building, atc. (Specifi	- At home, farm, stre	et, factory, office		281. LOCATION (Street	and Number or R	ural Route Number,	
E	4 Homicide determined	January, etc. (opeca)	,,			City or Town, State)			
COMPLETED	29a, CERTIFIER 1 CERTIFYING PHYSICIAN	N: To the best of my knowle	dge, death occurred a	st the time, data	and place, and due	to the cause(s) and mar	nner as stated,		
OM	one) 2 MEDICAL EXAMINER: 0							use(a) and manner as stated.	
BE C	296. SIGNATURE AND TITUE OF CENTIFIER	On.			29c. LICENSE NUN		29d, DATE SIG	INED (Month, Day, Year)	
TO B	Hon 7 Charle	iller M	1.0		294.	53	> Feb	uan11995	
-	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF OEAT	TH (ITEM 27) (Type, Pri	int)		CKUILLE		J	
	ALAN J. CHANACES			LOVE K	D RO	KUILLE	MO Z	25202	
	FFB 0.3 1005	32. REGISTRAR'S SIGNAT	OF Rad De						



FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE.

	REGISTRAR				CERTIF	CATE	OF D	EATH	REG. NO).			
		GRIE				-L			2. DATE OF DEATH MONTH	AT O	25	OZZGA	
14	4. SOCIAL SECURITY NUI	819	1 🗆 M 2 💢 F	6. AGE (In y	rs. lest birthday) YRS.	IF UNDER 1		UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) Feb. ,	937	Country)	ACE (State or Foreign	
Стоя	9a. FACILITY NAME (# not Washing to	n Count		al			own or L erst	OCATION OF DE	EATH	Was	y of DEA hing		
E L	10a. STATE	10b. COUNT	Υ		10c. CITY	, TOWN OR	LOCATION				10	Dd. INSIDE CITY	
L DIRE	MD 100, STREET AND NUMBE		ington		Hag	ersto		P CODE		1	ı.	LIMITS? X YES 2 NO	
FUNERAL	750 Dual						200	21740		U.S		AT COUNTRY?	
₽	11. MARITAL STATUS 1 Never Married 2 [3 Wildowed 4 Di		12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA	YES 2	₹ NO	lf y	es, specify	DENT OF HISPAN y Cuban, Mexica X NO Specify	NIC ORIGIN? (Specify Yes, Puerto Rican, etc.)		A. RACE Black, V Specify: WNO	- American Indian, White, atc. White	
once. COMPLETED	15, Di (Specify of Elementary/Secondary	ecedent's Edu	completed)		e. DECEDENT'S (Give kind of w life. Do NOT us	ork done du	UPATION ing most of	working	16b, KIND OF BU	SINESS/INDU	STRY		
MPL	11	(0-12)	College (1-4 or 5+)		Homemak	er			Own Hor	ne			
8 0	17. FATHER'S NAME (First,				16	. MOTHER'S NA	ME (First, Middle, Maider	Sumame)					
ed at	Alonza Ha							Alice					
1 1	19e. INFORMANT'S NAME (Typer/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
be	Neal B. Gl		Sr.										
must	20a. METHOD OF DISPOSITION 1X) Burlal 2 Cremation 3 Ramoval from State 4 Donetton 6 Other (Specify) 20b. PLACE AND DATE of DISPOSITION (Name of cemetary, crematory or other place) Parkhead Cemetery 2/8/95 Big Pool, MD												
iner	21. SIGNAPURE OF FUNE	AL SERVICE LI	CENSEE	Harr	wead C	22. NA	ME AND A	DDRESS OF FA	CILITY	2 1001	, MD		
medicai examiner must	The C	Grove Funeral Home P.O. Box 368 Hancock, MD 21750 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
any injury, or other traumatic event, the medical	shock, or iMMEDIATE CAUSE (f disease or condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERL CAUSE (Disease or in thet initiated events resulting in death) LA	ittions, sediete YING jury	a. DUE TO (C	on each fe i on as a co on as a co on as a co	line.				e Becom			Interval Batween Onset and Death	
ME		eur	me ser	rina	my to	the under	·w	feete	PERFO	RMED?	AN CC OI	ERE AUTOPSY FINDINGS MALABLE PRIOR TO DMPLETION OF CAUSE F DEATH? YES 2 100	
8 8	DID TOBACCO 25. WAS CASE REFERRED		RIBUTE TO CAU		PLACE OF DEAT	S NO		UNCERTAIN	1 🗆 📗			•	
SICI)	EXAMINER?		HOSPITAL:			OTHER:		□ Residence	6 Other (Specify)		-		
marked, or BY PHYS		Pending Investigation	28a. DATE OF II (Month, Day	NJURY	28b. TIME	OF 28	c. INJURY WORK?		28d. OESCRIBE HOW	INJURY OCCUI	RED		
28 is TED	2 Accident 3 Suicide 6 4 Homicide	Could not be detarmined	26e. PLACE OF building, at	INJURY — /	At home, farm, s	reet, factory	, office		28f. LOCATION (Street City or Town, State		Rural Rout	e Number,	
ANT: If item COMPLE									to the cause(a) and ma			nd manner as stated,	
BE	296. SIGNATURE AND TITE	OF CERTIFIE	Ale		Δ		290	C. LICENSE NUM	RBER	29d, DATE S	HIGNED (M	ogth, Day, Year)	
TO	30. NAME AND ADDRESS OF THE STATE OF THE STA	L/0	O COMPLETED CAUSE	55	25	NA IN	CATE	N EONTLET	AMST	OSP.	(() Cres	Jann int	
		995	Julie Daniele										
			W.	7								OHMH-1/5 Rev 1/	

2. DATE OF DEATH

		Beatri	7	V.	(250	4				2. DATE OF MONTH	DEATH D	AY 4
		4. SOCIAL SECURITY NUMBER 219-36-489!		5. SEX 1 M 2 X F	6. AGE (In		birthday) YRS.	IF UNDES	DAYS	IF UNDER	MIN.	7. DATE OF (Month, Di MAY	18,	1894
	TOR	9a. FACILITY NAME (If not instit NATIONAL I RESIDENCE OF DECE	UTHE	,	ME					R LOCATI	ON OF DE			9c. CO MOI
(WH)	DIRECTOR		Ob. COUNTY	ERICK	co.		10c. CIT	FREI	DER]	ČK				
anal per	VERAL	100. STREET AND NUMBER 313- E.	3rd	STREE	T				101	ZIP COD	701			10g. CI
21215-0020 al or attending physiciant for use as the burial-term	BY FUN	11. MARITAL STATUS 1 Never Married 2 M 3 Widowed 4 Divorce		12. WAS DECEDEN FORCES?	YES	2 N	MED O		If yes, sp	ENDENT Cobe	n, Maxicar	IC ORIGIN? (S n, Puerto Rice	pecify Yes n, etc.)	or No-
21 10 m	COMPLETED	15. DECEE (Specify only h Elementary/Secondary (0-12 1 2		CATION completed) College (1-4 or 5		(GIV	EDENT'S to kind of v Do NOT us URS	vork done se retired.)	CCUPATIO during mo	ON st of working	ng	16b. KII	OF BUS	SINESS/II
YLA by the be def	BE CO		S E.	GEESE	Y						ANI	NE (First, Midd VIE M	AY S	SUNI
	10	198. INFORMANT'S NAME (Type REV.DR. RE	ICHA	ARD		_			_		or Aural A	ROC	KVII	n, State, 2 LLE
LTIMORE, ath. Page 6 may be ineral director, page		20e. METHOD OF DISPOSITION 1 M Burlal 2 Cremation 4 Donation 5 Other (S) 21. SIGNATURE OF FUNERAL S	3 Rame				ND DATE OF	ET (CEME	TER	Y]	1/31		EDEI
A 9 2 . 3		· Wh	nb	moon					HYS	ONG	CO.	, INC	.N.V	N.,
68760, Becured within 24 hours after and completely filled in by the burial. cremation, or removatic event, the medical		23. PART I. Enter the dise shock, or hee IMMEDIATE CAUSE (Final disease or condition resulting in death)	rt fellure.	a	It coused to	ine.	A	rls	the mo	da of dy	ing, such	ln se cerdiac	or reapi	ratory a
OX 68 to be execute be be executed and solicition and prior to but traumatic	FICATION	Sequentially list condition if any, leading to immedia cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	te II	OUE TO	ION AS A O	ONSEO	UENCE OF	ur do	ner Lu	la	10	go.	eas	.0
OS, P.O. E he death certifical the attending phy Mental Hyglene i jury, or other	CERTIFIC	resulting in deeth) LAST	L	, Can	-90	87	n	P	La	~7	1	ail	im	1
RECORL requires that the signed by the Heath and shows any in	I: MEDICAL	PART II. Other significant	condition	e contributing to	deeth but	not re	eulting i	n the ur	nderiying	Causay	given in i		PERFOR	MED?
F VITAL SICIAN: The law certificate has the the State Dept d, or Item 23	SICIAN	25. WAS CASE REFERRED TO BEXAMINER? 1 YES 2 NO	MEDICAL	HOSPITAL:	ER/Outpati	ent 3 [DOA	OTHER 4 X I Num	₹:			ck only one)	necifu)	
O ž 荒 ž 🛎	BY PHYSI	27. MANNER OF DEATH 1 Natural 5 Per 2 Accident Inv	nding estigation	28a. DATE OF (Month, D			28b. TIME	E OF	28c. INJU	-		28d. DEŞCRI		NJURY O
9 2 5	ETED	4 Homicide det	uld not be ermined	28e. PLACE O building,	F INJURY — etc. (Specify	At hom	ie, ferm, s	treet, fact	ory, office			28t. LOCATIO City or To	N (Street a wn, State)	and Numb
	COMPLI			CIAN: To the best of R: On the bests of e										
m m 2 2	BE	296. SIGNAMINE AND TITLE OF	CENTIFIER	0()	11	0,	2011	1		250, 1901	NSE NUM	HER 1		29d. 04

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DR. CHARLES KARESH- MT. AIRY, MD. 21771

82. REGISTRAR'S SIGNATURE ilia d'avelson Rordall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

FOR STATE REGISTRAR

2

31. DATE FILED (Month, Day, Year)

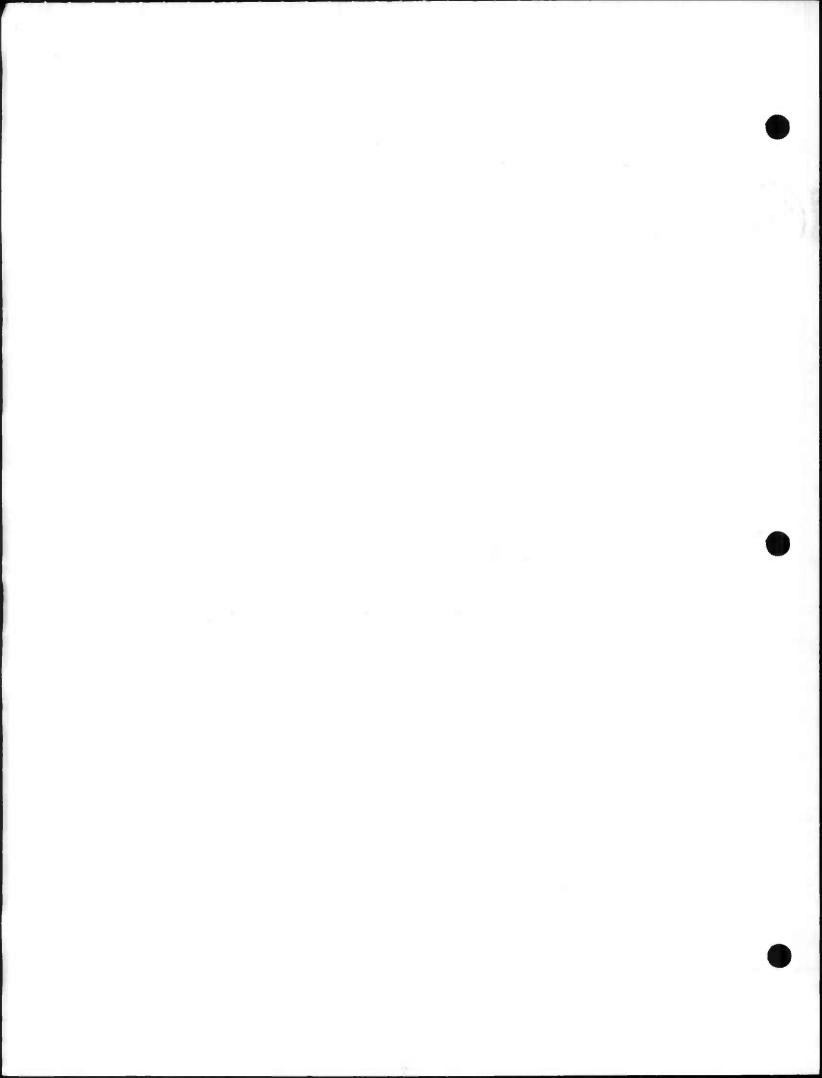
02 1995

1. DECEDENT'S NAME (First, Middle, Last)

3. TIME OF DEATH 9:00 8. BIRTHPLACE (State or Foreign 18,1894 MARYLAND 9c. COUNTY OF DEATH MONTGOMERY CO. 10d. INSIDE CITY LIMITS? YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, atc. Specify: WHITE D OF BUSINESS/INDUSTRY NURSING e, Meiden Surneme) AY SUNDAY ity or Town, State, Zip Code) KVILLE, MD.20850 20c. LOCATION — City or Town, State FREDERICK, MD. N.W., WASH., DC Approximate interval Between or reapiratory arrest, Onset and Death 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO E HOW INJURY OCCURED N (Street and Number or Rural Route Number, vn, State) place, and due to the cause(s) and manner as stated.

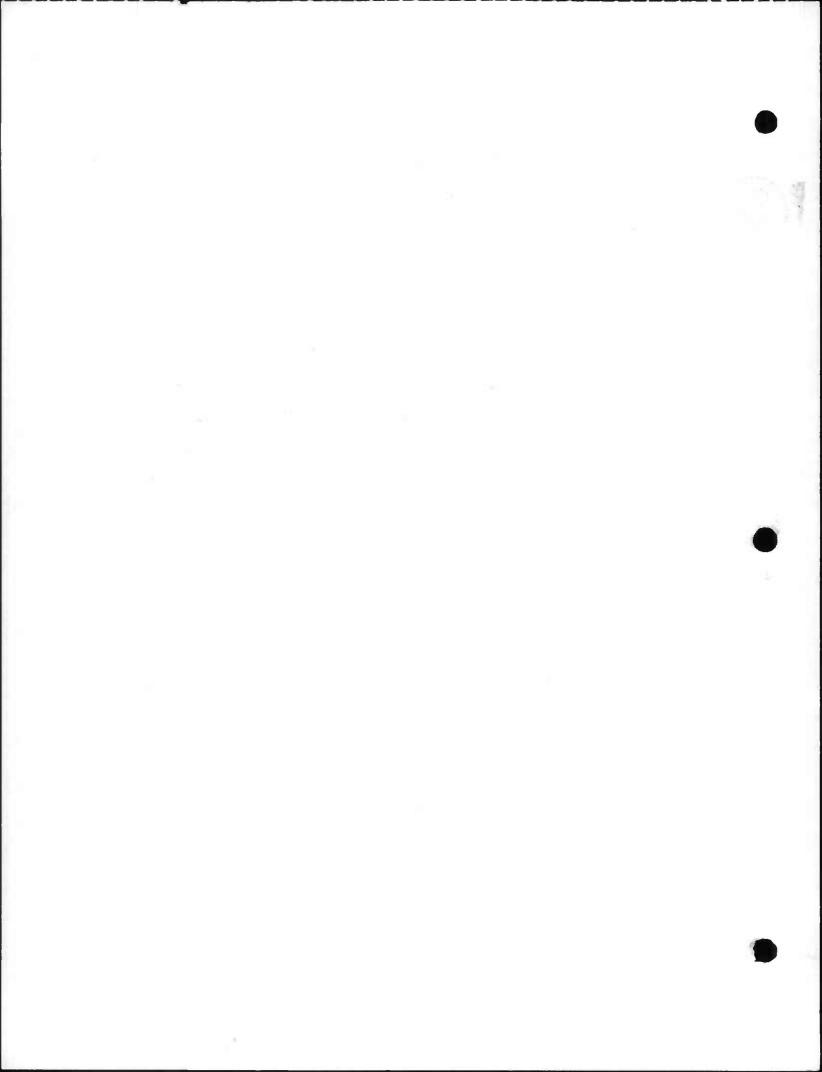
DHMH-16 Rev 1/89

E SIGNED (Month, Day, Year)



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		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF HEALTH AND CATE OF DEATH	MENTAL HYGIENI REG. NO.	Ε	
		1. DECEDENT'S NAME (First, Middle, LI	ORAHAM			2. DATE OF DEATH MONTH DA	95	3. TIME OF DEATH 910 A M
	1	4. SOCIAL SECURITY NUMBER 218-52-908	7 1 1 M 2 12 F -	7 D YRS. "	IF UNDER 1 YEAR IF UNDER 24 HRS. ONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Morith, Day, Year)	, Country)	LACE (State or Foreign
1	тов	9a. FACILITY NAME (If not institution, gi		b CTL	columbia, M.	DEATH .	9c. COUNTY OF DEA	0
)	DIRECTOR	Maryland How		10c. CITY,	TOWN OR LOCATION Clarksville			IOd. INSIDE CITY LIMITS? YES 2 \ NO
	FUNERAL	100. STREET AND NUMBER 6114 Tulane	Drive		101. ZIP CODE 21029		10g. CITIZEN OF WH. U.S.A	
	BY	11. MARITAL STATUS \(\sum_{\text{Nover Married}} 2 \) Married 3 \) Widowed 4 \(\sum_{\text{Divorced}} \) Divorced	12. WAS DECEDENT EVER I FORCES? 1 — YES IF YES, GIYE WAR OR D	2 X NO	13. WAS DECENDENT OF HISP If yea, specify Cuban, Maxi 1 YES 2 M NO Speci	can, Puarto Rican, etc.)	Black, \	- American Indian, Whita, atc. White
	PLETED	15. DECEOENT'S a (Specify only highest gr Elementary/Secondary (0-12)		life. Do NOT use i	k done during most of working	16b. KIND OF BUS		
d at once.	SE COMPL	17. FATHER'S NAME (First, Middle, Last) Tyree William			18. MOTHER'S N Ethel	AME (First, Middle, Maiden S Louise G	Sumame) Sould	
e notified	TO B	190. INFORMANT'S NAME (Type/Print) Mildred I. Grah	am	6114 Tu	odress (Street and Number or Rura lane Dr., Clar	Route Number, City or Town KSVille, MD	n, State, Zip Code) 21029	
er must be		20s. METHOD OF DISPOSITION 1 Deurisi 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE	emoval from Stata	D. PLACE AND DATE OF metary, crematory of othe CINITY Mem	orial Gardens	2/1/95 Wal		
val.		> Muhail	JBylu		22. NAME AND ADDRESS OF P	t. NW Washi	ington, D.	
event, the medical		23. PART I. Enter the diseases, abock, or heart failu IMMEDIATE CAUSE (Final disease or condition resulting in death)	a.	d tha death. Do not sech line.	anter tha moda of dying, su	ch as cardiac or reapir	atory arrest,	Approximata Interval Between Onset and Death
	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	A CONSEQUENCE OF):				
ino menta / injury,	AL	PART II. Other significant condit	ilona contributing to death to	out not resulting in	tha underlying cause given i	n Part I. 24a. WAS AN / PERFORI		/ERE AUTOPSY FINDINGS
hows an	MEDI					1 🗆 YES 2	9/10	ompletion of cause of death?
Item 23 s	SICIAN:	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	-	26. PLACE OF DEATH				
8 5	PHYSI	1 VES 2 NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Out	pertient 3 DOA 4	Nursing Roma 5 Residence OF 28c, INJURY AT	6 Other (Specify) 28d. DESCRIBE HOW IN	HIM OCCUPED	
	BY PI	1/Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR	WORK?			
item 28 is	ETED.	3 Suicide 8 Could not datarmined	building, atc. (Spe			281. LOCATION (Street ar City or Town, State)		te Number,
WITHIN /2 HOURS	COMPLETED	one) 2 MEDICAL EXAM	IINER: On the basis of examination		at the time, data and place, and du			nd manner as stated.
를 듣	TO BE	29b. SIGNATURE AND TITLE OF CERTI	10 Interni		29c. LICENSE N	37013	DATE SIGNED 44	fonth, Pay, Year)
		30 NAME AND ADDRESS OF PERSON		ATH (ITEM 27) (Type, Pr	in) Little Pat	went pk	Co(U)	1. (.44)
		FEB 02 19	95 Julia David	LOW RONDALL			,	



TO BE COMPLETED BY FUNERAL DIRECTOR

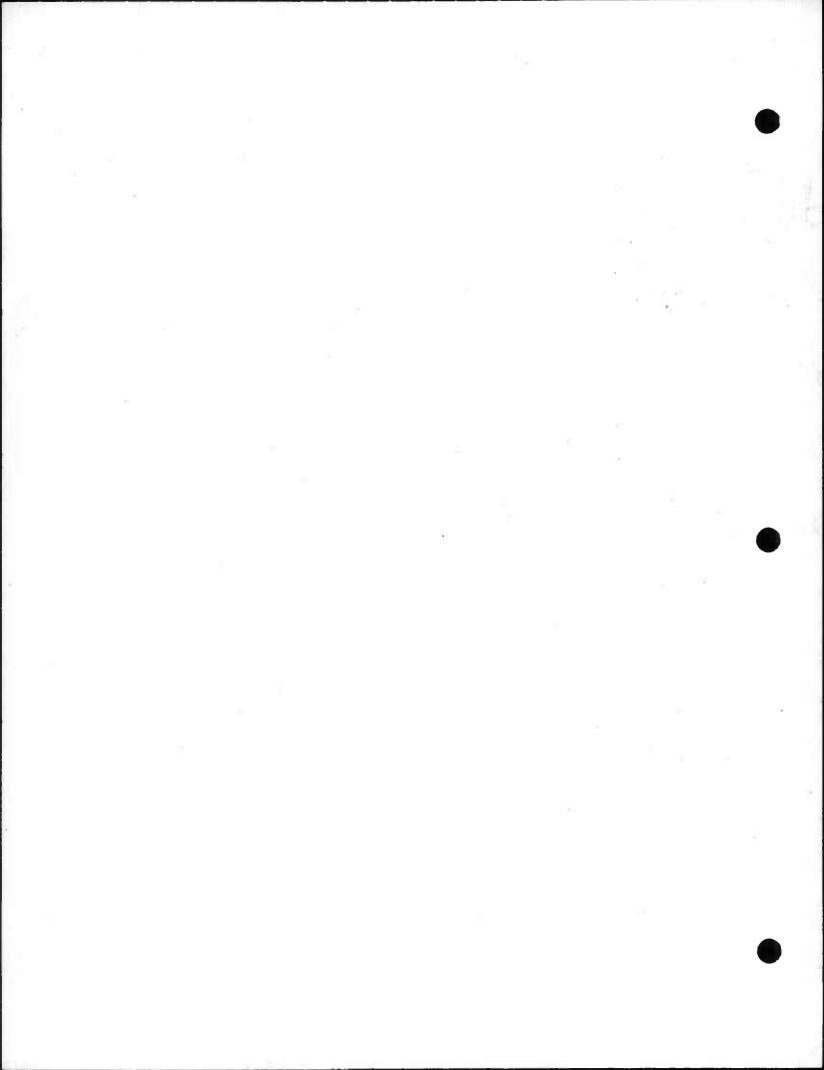
1 - STATE REGISTRAR		SIMIE UF I	WANTL					DEAT		MENI	AL HYGIEN REG. NO.	E		
1. DECEDENT'S NAME (First	, Middle, Last)										TE OF DEATH			3. TIME OF DEATH
BERNARD				GRU	BER					FEB	RUARY 2	, 19	95 FEAR	4:55AM M
4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE	(In yrs. las	t birthday)		R 1 YEAR	IF UNDER		7. DAT	E OF BIRTH		B. BIRTH	HPLACE (State or Foreign
088-12-97	56	1 📉 M 2 🗆 F		71	YRS.	MONTHS	DAYS	HOURS	MPH.	þďŤ	. 13, 1	923	NE	W YORK
9a. FACILITY NAME (If not in						96. CIT	Y, TOWN	OR LOCATI	ON OF D	DEATH		9c. COL	JNTY OF D	EATH
KENSINGTON		NS REHAB.	CE	NTER			KE	NSIN	GTON	1		MON	TGOMI	ERY
RESIDENCE OF DEC	10b. COUNT	Y			100 CIT	v muuu	OR LOCA	TION						
MARYLAND		TGOMERY				_	NGTO							10d. INSIDE CITY LIMITS?
10e. BTREET AND NUMBER	1101	TOOTIERT			10	PNOI		I. ZIP CODI				40- 00		1 TYES 2 T NO
3000 Mc	COMAS	AVENUE					10	208						STATES
11. MARITAL STATUS	ZSEDY	12. WAS DECEDEN FORCES? 1	X YES	N U.S. AR	MED	13					3IN? (Specify Yea o Rican, etc.)	or No-	14. RACE	E — American Indian, k, White, etc.
1 Never Married 2 3 Widowed 4 X Divo		IF YES, GIVE Y	WAR OR D	ATES				2 X NO			o riican, etc.)		Speci	My:
	EDENT'S EDU		WW I	_										WHITE
(Specify ont	y highest grade	completed)		(G)	CEDENT'S we kind of a Do NOT us	work done	during m	ON ost of working	ng	1	86. KIND OF BUS	INESS/IN	DUSTRY	
Elementery/Secondary (0)-12)	College (1-4 or 5	+)		OSTA			Œ			U.S.	COVE	RMMFI	NT
17. FATHER'S NAME (First, M	liddle, Last)				00111		10110	_	JED'C N	AME /Fire	t, Middle, Maiden		IUITLI	MT
HERMAN (GRUBER							200			APIRO	SUTTETNE)		
19a. INFORMANT'S NAME (7	ype/Print)			198	. MAJUNG	ADDRES	S (Street				mber, City or Town	State 7	in Cortel	
DAVID GE	RUBER	(SON	1)								LEM, PA			
204, METHOD OF DISPOSIT	igh		201	. PLACE	AND DATE	OF DISPO	SITION (N	sme of		D/	TE 20c. LO		City or To	own, State
1 🔀 Burlel 2 🗆 Crematic 4 🗆 Donation 5 🗆 Other	(Specify)	oval from State	1 K	ING	DAVI	Der ME	MORI	AL G	ARDE	EN 2				H, VIRGINIA
21. SIGNATURE OF FUNEINA	L SERVICE LI	perdill)				22	NAME A	ND ADDRES	SS OF F	ACILITY	O MEMOR	T A T	CILAR	
▶ 4	41.5	thy	1	0										PELS, INC.
23. PART I. Enter the di	iseases of	complications the	t ceuse	d the de	ath. Do r	not ente	r the mo	de of dvi	DO SUC	ch aa ca	RE-RUCK	CVILLI	LE, MA	ARYLAND 2085
anges, or n	eart tellure.	List only one ceu	ise on e	ech line.								atory an	Tout,	Interval Between
iMMEDIATE CAUSE (Findisease or condition	101			Mo	tasi	Tali.		000		0	2.000			Onset and Death
resulting in death)	7	DUE TO	(OR AS /	CONSEC	DUENCE O	P):		JU JE 6	<u>n</u>		mul	_		tal
	-	b.		Co	n900	ctin	0	40	ant		meer fail	LVP	_	j
Sequentielly list conditi If any, leading to imme	ons,			CONSEC	DUÉNCE OI	F):		_		_				
CAUSE (Disease or Inju		c		Ga	by	10	lesti	nal	BI	Peed	L			
that initiated events resulting in death) LAS	"	DUE TO	(OR AS A	CONSEC	DUENCE OF	F):								
readining in dealin, LAS		d												
PART II. Other aignifice	nt condition	a contributing to	deeth b	out not re	esulting	in the u	nderiyin	g ceuse g	lven in	Part i.	24s. WAS AN	AUTOPSY	24b.	. WERE AUTOPSY FINDINGS
		_									PERFOR		1	AMAILABLE PRIOR TO COMPLETION OF CAUSE
											1 TYES 2	M NO		OF DEATH?
DID TOBACCO U	SE CONT	RIBUTE TO CA	USE O	F DEAT	TH YE	SΠ	NO [1 UNC	ERTAI	N IA				1 TES 2 NO
25. WAS CASE REFERRED TO			-		E OF DEAT			3 0110		TT KEN				
EXAMINER?		HOSPITAL: 1 Inpetient 2	ER/Outs	patient 3	□ DOA	OTHE		ne 5 🗆 Re	aidence	6 Ot	her (Specify)			
27. MANNER OF DEATH		28a. DATE OF	INJURY		28b. TIM	E OF	28c. INJ	URY AT	Sidelice		ESCRIBE HOW IN	JURY OC	CURED	
	Pending Investigation	(Month, D	ay, Yesr)		INJ	M	_	YES 2	NO					
2 Suitelde —	Could not be	28e. PLACE O building,	F INJURY	— At hor	me, farm, s	street, fac	tory, offic	•		28f. LC	CATION (Street a	nd Numbe	r or Runal R	loute Number,
	detarmined	bullating,	etti. (Spec	снуу						CA	ly or Town, State)			
29a. CERTIFIER 1 CERT	IFYING PHYSI	CIAN: To the best of	my know	ledge, des	nth occurre	d at the	time, date	and place,	and due	e to the c	ause(a) and man	ner as ste	ted.	
) and manner ea stated.
29b. SIGNATURE AND TITLE	OF CERTIFIES	3 /						29c. LICE	NSE NU	MBER		29d. DAT	E SIGNED	(Month, Day, Year)
Chah	Ahas	Mu						D4	34	96		> 3	2-2	-95
30. NAME AND ADDRESS OF	PERSON WH	WAT IN	E OF DE		mdo	A 4	Ra	1	K	DVV	ile l	ND	20	RS
31. DATE FILED (Month, Day	195 9	132 Argisin	MA SE	ALTU.	1100	- -	0000	4	0.0	CFV	, , ,	-		33 —
LEDONO	0													

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

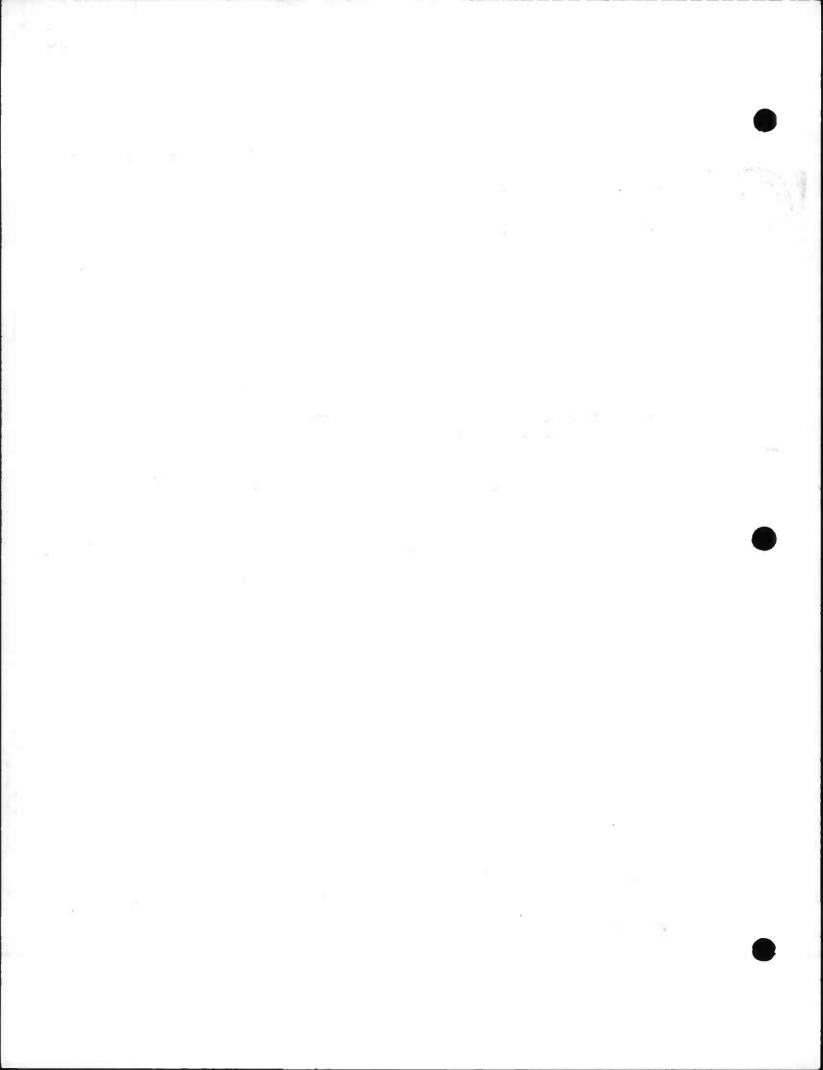
BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal. IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	The second second second second second
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		IENTAL HYGIEN	E	
į	1. DECEDENT'S NAME (First, Middle, Last)	ps.				DATE OF DEATH	V V	3. TIME OF DEATH
	MATILDA		_DEN	BERG		yanuary -		5 4300
		5. SEX 6. AGE (III	n yrs. lest birthday) 98 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	NOV. 5, 18	896 I	BIRTHPLACE (State or Foreign Country) NEW JERSEY
œ	9e. FACILITY NAME (If not institution, give stre		THOMON		OR LOCATION OF DEA	TH	9c. COUNTY	
OT.	HEBREW HOME OF G	REATER WASH	INGTON	ROCKVI			MONT	TGOMERY
DIRECTOR	10a. STATE 10b. COUNTY MARYLAND MONTG	GOMERY	10c. CIT	Y, TOWN OR LOCAT				10d. INSIDE CITY LIMITS? 1 X YES 2 NO
AL	10e. STREET AND NUMBER			10f	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	6121 MONTROSE RC				20852			ED STATES
В	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, GIVE WAR OR DA	2 X NO	13. WAS DEC If yea, apo	ecify_Cuban, Mexicen,	C ORIGIN? (Specify Yea , Puerto Ricen, etc.)	or No — 14.	RACE — American Indian, Black, White, etc. Specify: WHITE
E	t5. DECEDENT'S EDUCA (Specify only highest grade co	TION ompleted)	(Give kind of s	USUAL OCCUPATION	ON st of working	t6b. KIND OF BUS	SINESS/INDUST	(RY
, E	Elementary/Secondary (0-t2)	College (1-4 or 5+)	HOMEMAK	se retired.)		OLINI	HOME	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		HOPIEPAN	LK	18 MOTHER'S NAM	E (First, Middle, Maiden	HOME	
BE C	MORRIS WEITZ				LENA JA		Surrierne)	
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	nd Number or Rural Ro	oute Number, City or Town	n, State, Zip Coo	de)
	MARTIN GOLDENBER	(===,	21 CA	PE JASMI	NE COURT-	-GAITHERSE		
	20a, METHOD OF DISPOSITION 1 A Burlel 2 Cremation 3 Ramov 4 Donation 5 Other (Specify)	ral from State 20b.		CEMETERY	me of			or Town, Stata CK, NEW JERSEY
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE		DANZAN	SKY-GOLD			HAPELS, INC.
9	Frank a	Som						MD. 20852
	23. PART I. Enter tha diseasea, or co shock, or haart failura. Li	mplications that causad	the death. Do r	not antar the mo	da of dying, auch	as cardiac or respi	ratory arrest	
	iMMEDIATE CAUSE (Final disease or condition	A					2	intarvai Batween Onaet and Daath
ļ	resulting in death) a.	ACUTE DUE TO (OR AS A	MYOC	AKDIA	LING	ARCTION	}	SUDDEN
_	-				210			į į
5	Sequantially list conditiona, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	F):	012	G-M-3C		
ICA	cause. Entar UNDERLYING CAUSE (Disease or injury	But 10 100 10 1						
CERTIFICATION	that initiated evants reaulting in daath) LAST	DUE TO (OR AS A	CONSEQUENCE OF	F):				
	d.							
CAL	PART II. Other significant conditions	IN FARCT	it not rasuiting i	in the underlying	cause given in P	art i. 24a, WAS AN. PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE
PHYSICIAN: MEDIC	1014	LIVEARCE	1) 0	MENIT		1 🗆 YES 2	NO NO	OF DEATH?
Σ ::	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YE	S D NO K	UNCERTAIN			1 TYES 2 NO
CIAI	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEAT	H (Check only one)				
YSI	1 YES 2 NO	t 🗆 Inpetient 2 🗆 ER/Outpe			5 - Realdence 8	Other (Specify)		
	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY WO	RK?	28d. DEŞCRIBE HOW IN	JURY OCCUR	ED
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28s. PLACE OF INJURY	— Al home, ferm, s	M 1 7		281, LOCATION (Street a	nd Number or F	Burai Routa Number
H	4 Homicide determined	building, atc. (Specif	fy)			City or Town, State)		,
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSICI.	AN: To the best of my knowle	edga, death occurre	ed at the time, date	and place, and due lo) the cause(s) end man	ner as stated.	
WO.								euse(a) and manner ea stated.
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	1.45 1	DL.	-1 -1-	29c LICENSE NUMB	EH ALC	29d. DATE SK	GNED (Morth, Cay, War)
TO B	Milara	— ricerdi	ing rry	si aran	0180	84	teb	may 1, 1995
	30. NAME AND ADDRESS-OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) /3/00.	1500	JEZHBI	M.P.	PAT	ECH MID.
	31: DATE FILED (Month, Day, Year)	32. BEGISTRAR'S SIGNA	TURE TYRE	DITTE	we rei)	REGUEVIL	LE M	0 50007
	FEB 03 1995 Au	la Davidson Ran	dall					



. BOX 68760, BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death, Page 6 may be retained by the hospital or attending physician	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transfer effect within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death ce	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fun De filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or o

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMEN	T OF HEALTH AND MENTAL	HYGIENE
CERTIFICAT	E OF DEATH	REG. NO.

	1 - FOR STATE OF MA		RTMENT OF H		IENTAL HYGIENE REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH			
	Esco Norman Garlitz				February 2	1995	9:32 р м			
		AGE (In yrs. last birthday		IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	HPLACE (State or Foreign			
	217-14-4663 1 R M 2 F	79 YRS.			Oct 15 191	_	aryland			
DIRECTOR	Frostburg Hospital Inc.		1	stburg	ATH	9c. COUNTY OF DEATH Allegany				
3EC	10a. STATE 10b. COUNTY	10c. C	CITY, TOWN OR LOCAT	ION	-		10d. INSIDE CITY			
D.	Maryland Garrett		Frost				LIMITS? 1 YES 2 NO			
FUNERAL	10e. STREET AND NUMBER		101	ZIP COOE		-	WHAT COUNTRY?			
JNE	624 Beall School Road 11. MARITAL STATUS 12. WAS DECEDENT E	VED IN 11 0 ADMED	12 490 050	21532						
BY FU	1 Never Married 2 Merried FORCES? 1 IF YES, GIVE WAR	YES 2 NO	If yea, ap	ecify Cuban, Maxican, 2 10 NO Specify:		r No— 14. RAC Blac Spec	E — American Indian, k, Whifa, atc. ://y: White			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give kind o	"S USUAL OCCUPATION work done during mo	ON st of working	16b. KIND OF BUSIN	ESS/INDUSTRY	witte			
PLE	Elementary/Secondary (0-12) College (1-4 or 5+)	life, Do NOT	uso rotirod.) Lectridia	-	Monuf	acturing	Tines			
NO.	17. FATHER'S NAME (First, Middle, Last)		rectitata		I Latitut :		3 IIIes			
Ö		litz		Rhoda	ic (riist, Middle, Maiden St	Robes	son			
BE	19a. INFORMANT'S NAME (Type/Print)		NG ADDRESS (Street a		oute Number, City or Town,		5011			
5	Flossie Garlitz				Frostburg,		32			
	20a. METHOD OF DISPOSITION 1 ★ Burial 2 □ Cremetton 3 □ Ramoval from State	20b. PLACE AND DAT	E OF DISPOSITION (Na	own State						
1	4 Doneflon 5 Other (Specify)	Blocher	Cemeter	Feb.5	,95 Fro	stburg,	Maryland			
	show R. Luss	1	22. NAME AF	rost Ave	Durst Fi	uneral l	Home 21532			
	23. PART I. Enter the diseases, or complications that completely are been followed by the party of the party	aused the deeth, Do					Approximate Interval Between			
	shock, or heert fellure. List only one ceuse on eech line. IMMEDIATE CAUSE (Final									
	resulting in deeth)	den ca	wdiac	dealt			MINUTES			
	r .						MONTHS			
CERTIFICATION	Sequentially list conditions, if say leading to immediate	AS A CONSEQUENCE	OF):			MANY				
8	if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury									
	thet initiated evente DUE TO (OF resulting in death) LAST	AS A CONSEQUENCE	OF):							
5	d									
AL	PART II. Other eignificent conditions contributing to de	eth but not resulting	g in the underlying	feeler in P	Part I. 24a. WAS AN AL PERFORMI	ED?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
M	Hyperlinsis	0			_ ^	,	1 YES 2 NO			
ä	DID TOBACCO USE CONTRIBUTE TO CAUS			UNCERTAIN	A					
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	11	OTHER:							
H	1 ☐ YES 2 ☐ NO 1 ☐ Inpatient 2 ☐ ET 27. MANNER OF DEATH 280. DATE OF INJ	VOutpatient 3 DOA	4 Nursing Hom	5 Residence 8	Other (Specify) 28d. DESCRIBE HOW INJ	timy occupen				
BY PI	1 Netural 5 Pending (Month, Day,	(bar)	NJURY WO	RK?	zed. DESCRIBE NOW INS	OHY OCCURED				
	a Decident	JURY — At home, ferm (Specify)	s, atreet, factory, office		28f. LOCATION (Street end City or Town, State)	Number or Rural	Route Number,			
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the base of axamination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(e) and the cause(e) a									
	29b. SIGNATURE AND TITLE OF CERTIFIER		ton, army opinion, a	29c. LICENSE NUME			A 11 /2 /2 /2 /2 /2 /2 /2 /2 /2 /2 /2 /2 /2			
BE	Asidler			(Month, Day, Year)						
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE (OF DEATH (ITEM 27) (Type	pe, Print)		1	73/1)			
	Harit S. Sighillar	9257	Bishop	Walsh	Rd, Cu	mbi	MD 21502			
	31. DATE FILES (Month, Dev. Ner) 32. REGISTRAR'S	LON-RONALL	•		/	,				

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Secretary and grow, Loses, Lawer ROSS Giff Ethics on the Control of Control	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			MENTAL	HYGIEN	E		
578—48—2695 **In all and the property of the						MONTH	OF DEATN	95	YEAR	
SECURITY NAME of and production of the productio		2.5				(Month,	Day, Year)		Countr	γ)
SUBLIVED AT HOSPITAL Secondary Second				CITY, TOWN O	R LOCATION OF D	1 3	21,			
Section Sect	Suburban Hosp									
Security Security	10a. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCAT	ION					10d. INSIDE CITY
SA SA SA SA SA SA SA SA	Md. Montgom	ery		Rockv	ille					
11. MARTIAL STATUS There Martied				10f.				10g. CITIZE		
Clocky only highest good completed Clocky only highest good completed Clocky only highest good completed Clocky only highest good completed Clocky only only only only only only only onl	1 Never Married 2 Married	FORCES? 1 YES	2 1 NO	If yes, spe	cify Cuban, Maxic	an, Puarlo R		or No — 1	4. RACE Black	— American Indian, t, White, atc.
Elementary@lecondary (6-12) 2 Sales Clerk Clothing 17. FATHER'S NAME (First, Modes, Last) Daniel Rosensweig 18. MALHING ADDRESS (Piret and Microber or Name (First, Modes, Maldon Summan) Katy Scher 17. FATHER'S NAME (First, Modes, Last) Daniel Rosensweig Sandra Shane 17. PATHER'S NAME (First, Modes, Last) Sandra Shane 17. Pather's Name (First, Modes, Last) Sandra Shane 17. Pather's Name (First, Modes, Last) Sandra Shane 17. Pather's Name (First, Modes, Last) Sandra Shane 17. Pather's Name (First, Modes, Last) Sandra Shane 17. Pather's Name (First, Modes, Last) San	15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	(Give kind of work	done during mos	N st of working	16b.	KIND OF BUS	INESS/INDU	STRY	
17. PATREYS NAME (First, Models, East) Daniel Rosensweig Katy Scher 18. MOTHER'S NAME (First, Models, Marking Summany) Katy Scher Katy Scher Katy Scher 17. September of Part Rosen Marker Cay or Team, Stein, 2p Codal) 17. September of Part Rosen Marker Cay or Team, Stein, 2p Codal) 17. September of Part Rosen Marker Cay or Team, Stein, 2p Codal) 17. September of Part Rosen Marker Cay or Team, Stein, 2p Codal) 17. September of Part Rosen Marker Cay or Team, Stein, 2p Codal) 17. September of Part Rosen Marker Cay or Team, Stein, 2p Codal) 17. September of Part Rosen Marker Cay or Team, Stein, 2p Codal) 17. September of Part Rosen Marker Cay or Team, Stein, 2p Codal) 17. September of Part Rosen Marker Cay or Team, Stein, 2p Codal) 17. September of Part Rosen Marker Cay or Team, Stein, 2p Codal) 17. September of Part Rosen Marker Cay or Team, Stein, 2p Codal) 17. September of Part Rosen Marker Cay or Team, Stein, 2p Codal) 17. September of Part Rosen Marker Cay or Team, Stein, 2p Codal) 17. September of Part Rosen Marker Cay or Team, Stein, 2p Codal) 17. September of Part Rosen Marker Cay or Team, Stein, 2p Codal) 17. September of Part Rosen Marker Cay or Team, Stein, 2p Codal) 18. MARK AND ADDRESS (Stein And Address Cay or Team, Stein, 2p Codal) 19. Rosen Marker Cay or Team, Stein, 2p Codal) 19. Rosen Marker Cay or Team, Stein, 2p Codal) 19. Rosen Marker Cay or Team, Stein, 2p Codal Cay or Team, Stein, 2p Codal Cay or Team, Stein, 2p Codal Cay or Team, Stein, 2p Codal Cay or Team, Stein, 2p Codal Cay or Team, Stein, 2p Codal Cay or Team, Stein, 2p Codal Cay or Team, Stein, 2p Codal Cay or Team, Stein, 2p Codal Cay or Team, Stein, 2p Codal Cay or Team, Stein, 2p Codal Cay or Team, Stein, 2p Codal Cay or Team, 2p Codal Cay or Team, 2p Codal Cay or Team, 2p Codal Cay or Team, 2p Codal Cay or Team, 2p Codal Cay or Team, 2p Codal Cay or Team, 2p Codal Cay or Team, 2p Codal Cay or Team, 2p Codal Cay or Team, 2p Codal Cay or Team, 2p Codal Cay or Team, 2p Codal Cay or Team, 2p Coda Cay or Team, 2	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT use re	tired.)			Clot	hina		
Daniel Rosensweig 198. MALENG ADDRESS (Street and Murrow or Read Place Name Cap or Daniel 20 Decided) 199. METINGO OF DIRECTION 1729 Glastonberry Rd. Potomac, Md. 289. METINGO OF DIRECTION 299. METINGO OF DIRECTION 200. PLACE AND DATE OF DIRECTION (Name of Cap or Daniel 20 Decided) 210. PLACE AND DATE OF DIRECTION (Name of Cap or Daniel 20 Decided) 211. SUBMATURE OF PLANEAR SERVICE USDAY 212. NAME AND ADDRESS OF PRECITY 213. RAME AND ADDRESS OF PRECITY 214. CAP OF DECIDION (Name of Cap or Daniel Cap or D	17. FATNER'S NAME (First, Middle Last)		Sales	TELK	46 MOTHER: 0 M	ME (First 1)				
The INFORMANT'S NAME (Proprint) Sanctar Share 1729 Glastonberry Rd. Potomac, Md. 1729 Glastonberry Rd. Potomac, Md. 280 MAILING ADDRESS (Street and Minimow or Neuril Route Name). City or Your. State. Legislating of Control (Control)	The state of the s	a						Sumame)		
Secretarion or psendation Table Burlet 2 Certarion Table Burlet 2 Certarion Table Burlet 2 Certarion Table Burlet 2 Certarion Table Burlet 2 Certarion Table Burlet 2 Certarion Table Burlet 2 Certarion Table Burlet 2 Certarion Table Burlet 2		3	19b. MAILING AO	DRESS (Street a				n, State, Zip C	ode)	
1.13 Buttel 2 Ceremation 3 Removal from State Complex Country Complex Country Countr	Sandra Shane		1729 G1	Lastonb	erry Rd.	Poto	omac,	Md.		
22. NAME AND ADDRESS OF FACULTY Edward Sage I. Funeral Direction 1091 Rockville, Md. 20852 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory strest, shock, or heart fellium. List only one cause on each line. IMMEDIATE CAUSE (Finel diseases or condition—resulting in death) a. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A	120 Burlal 2 Cremetion 3 Remo	val from State cen	PLACE AND DATE OF D	place)	me of	DATE	20c. LO			
23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentially list conditions, it saying to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury C			ing Daviu	22 NAME AN	D ACORESS OF EA	CILITY				LCII, va.
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Fine) BUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A C	18/1	tel			-					Md. 20852
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27. MANNER OF DEATH 1. Netural 5 Pending Investigation 5 Use of Injury At Month, Day, Vear) 28a. DATE OF INJURY AT WORK? 1 USES 2 NO 28b. TIME OF INJURY AT WORK? 1 USES 2 NO 28d. DESCRIBE NOW INJURY OCCURED 28a. PLACE OF INJURY At homa, farm, street, factory, office 28c. Injury AT WORK? 1 USES 2 NO 28d. DESCRIBE NOW INJURY OCCURED 28a. PLACE OF INJURY — At homa, farm, street, factory, office 28c. Injury AT WORK? 1 USES 2 NO 28d. DESCRIBE NOW INJURY OCCURED 28b. TIME OF INJURY AT WORK? 1 USES 2 NO 28d. DESCRIBE NOW INJURY OCCURED 28c. CERTIFIER (Check only One) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 29c. CERTIFIER (Check only One) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER D36552 30b. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF GEATN (ITEM 27) (Type, Print) P. TAL WAY (121 MONTROSE ROAD, Rocky LLE MD. 2005 52 31. DATE FILED (Month, Day, Year) 22c. DESCRIBE NOW INJURY OCCURED 28d. DESCRIBE NOW INJURY OCCURED 28	EXAMINER?			THER:						
1. Netural	27. MANNER OF DEATH	26a. DATE OF INJURY	28b. TIME O	F 26c. INJ	JRY AT			JURY OCCU	RED	
3 Suicide 4 Nomicide 5 Could not be determined 26a. PLACE OF INJURY — At home, farm, street, factory, office 5 City or fown, State) 28b. LOCATION (Street and Number or Rural Route Number, City or fown, State) 29c. CERTIFIER (Check only orie) 2 MEDICAL EXAMINER: On the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER P. Fallwar M.D. 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF GEATN (ITEM 27) (Type, Print) P. TAL WAY (121 MONTROSE ROAD, Rocky, LLE MD. 2005) 31. DATE FILED (Month, Day, Year) 32. REGISTPAR'S SUPATURE.		(MORRI, Day, 19ar)	INJURY							
(Check only one) 2 MEDICAL EXAMINER: On the beat of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER P. Feb. 1, 1995 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) P. TAL WAY (121 MONTROSE ROAD, Rocky, LLE MD. 2005 52 31. DATE FILED (Month, Day, Year) 29c. LICENSE NUMBER D36552 Peb. 1, 1995	3 Suicide 6 Could not be	26s. PLACE OF INJURY building, atc. (Spe-	— At homa, farm, stree	ot, factory, office		261. LOCA City o	ATION (Street a or Town, State)	nd Number or	Rural F	loute Number,
P. Feb. 1, 1995 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF GEATH (ITEM 27) (Typo, Print) P. TALWAY 6/21 MONTROSE ROAD, ROCKYLLE MD. 20052 31. DATE FILED (MONTR. Day, Year) 32. REGISTMAN'S SUBSTITUTE.) and manner as stated.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATN (ITEM 27) (Type, Print) P. TALWAY 6/21 MONTROSE ROAD, ROCKY, LLE MD. 20052 31. DATE FILED (MONTR. Day, Year) 32. DEGISTRAR'S SUPATURE.	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU	MBER		29d. DATE S	BIGNED	(Month, Day, Year)
P. TALWAY 6/21 MONTROSE ROAD, ROCKY, LLE MD. 20052 31. DATE FILED (MONTR. Day, Year) / 32. BEGISTAR'S SUBSTITUTE.					D36552			▶ Fe	b.	1, 1995
31. DATE FILED (Month, Day, Year) 32. BEGISTPLAY'S SUBLETURE,					V115	MD.	2000	>		
	31. DATE FILED (Month, Day, Year)	32. BEGISTHAR'S SID	ATURE							

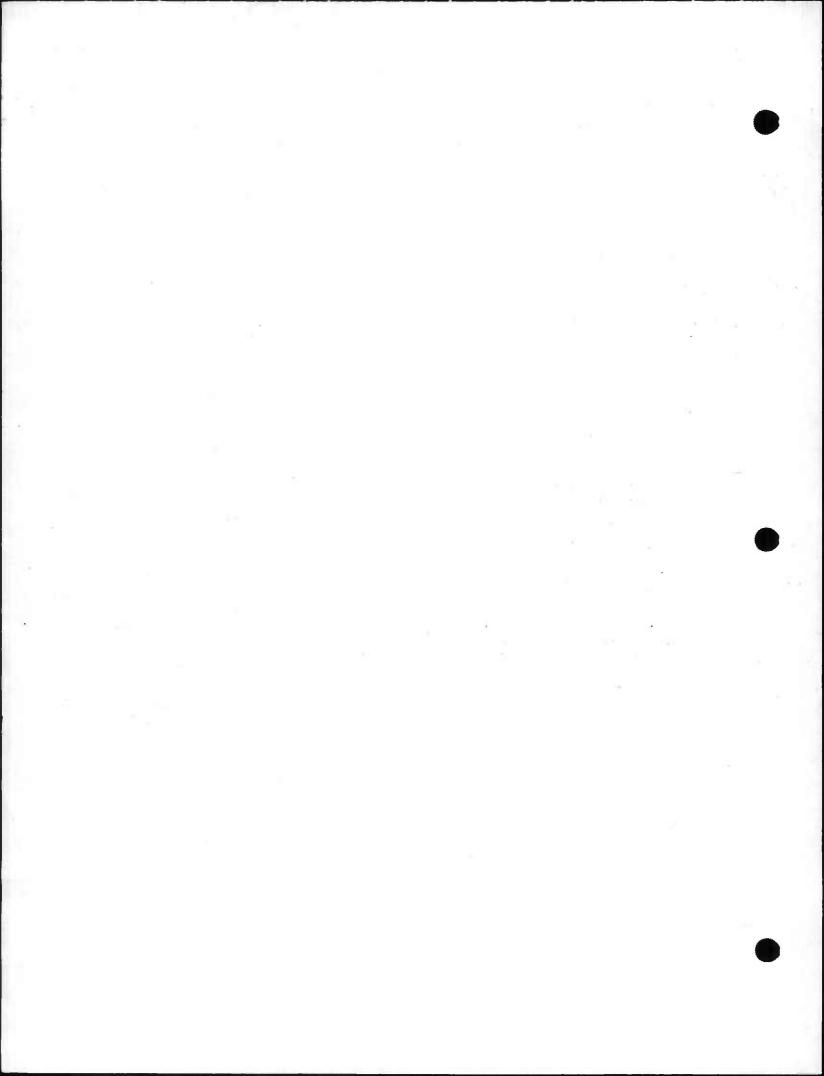
TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. **BALTIMORE, MARYLAND 21215-0020**

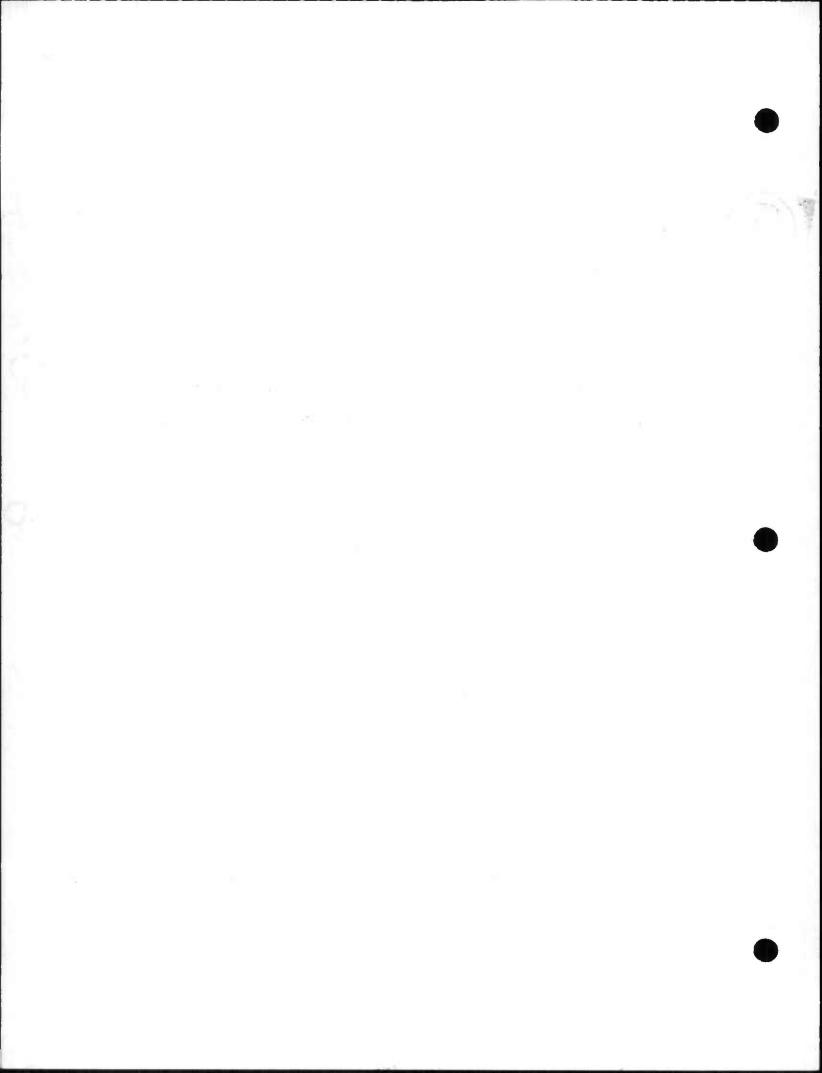
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician	TO THE FUNESAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnal-training the control of the	be new within 72 hours aren death with the State bept, or result and weithar hyberie prior to buriat, cremator, or remotal. IMPORTANT: If them 28 is marked, or frem 23 shows any injury, or other traumatte event, the medical examiner must be notified at once.
THE HOS	THE FUN	MPORTAN
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7///	FOR 1 - STATE REGISTRAR	STATE OF MA	RYLAND /	DEPAR		HEALTI F DEA	H AND		YGIENI EG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Lest)							2. DATE OF DEATH			YEAR 95	3. TIME OF DEATH A		
ron	4. SOCIAL SECURITY NUMBER 219-82-9862	1 - M 2 XF	AGE (In yrs. less	YRS.	IF UNDER 1 YEAR	-	ER 24 HRS.	7. DATE OF E	STOP	74	Count	HPLACE (State or Foreign ry) 7 land		
	9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY, TOW	N OR LOCA	TION OF D	EATH			NTY OF C			
	Great Oaks Center				Silve	r Spr	ing			Mon	ntgomery			
EC	10a. STATE 10b. COUNTY	,		10c. CIT	Y, TOWN OR LO	CATION						10d. INSIDE CITY		
FUNERAL DIRECTOR	Maryland Montgomery				Silver Spring						LIMITS? 1 YES 2 NO			
PAL.	10o. STREET AND NUMBER				101. ZIP COOE							WHAT COUNTRY?		
R	9824 Woodland Dri			20902						U.S				
	1X Never Married 2 Married FORCES? 1 YES 2 XN			D It yes, specify Cuban, Maxican, Puarto Rican,						tc.) Black, White, atc.				
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR OATES	1 TYES 2 NO Specify:						Specify: White				
COMPLETED	15. DECEOENT'S EDUC (Specify only highest grade	CATION completed)	18a. DE(CEDENT'S	USUAL OCCUP	TION	kina	16b. KIN	O OF BUS	INESS/INC	USTRY	WILLEC		
LET	Elementery/Secondary (0-12)	College (1-4 or 5+)	lite.	Do NOT u	se retired.)	most or wor	wig							
MP	N/A		Une	emp1	yed				N/A					
	17. FATHER'S NAME (First, Middle, Last)					-		AME (First, Middle						
BE	Nob Norberto Gar	cıa	1 404	MAILING	4000500 (0)			la Gern						
2	Graciela Garcia							Route Number, C Silver				20902		
	20g. METHOO OF DISPOSITION								_					
	20b. PLACE AND DATE OF DISPOSITION 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 2 / 6 / 29 ft 20c. LOCATION - City or Town, State 2 Donation 5 Dother (Specify) Secondary Cremetery or other place) Adelphi, Maryland													
	22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc.													
	► HH223 8	randon o	×									,MD 20901		
	23. PART I. Enter the diseasea, or o	complications that co	aused the de	nth. Do i								Approximate		
	ahock, or heart failure. List only one cause on each line.													
	disease or condition resulting in death) a. Tuteroselerosu a.													
	DUE TO (DR AS A CONSEDUENCE OF):													
NO O	Sequentially list conditions, b.													
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING													
윤	CAUSE (Disease or injury that initiated events DUE TO (DR AS A CONSEDUENCE DF):													
E	resulting in death) LAST													
LC	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY FINDINGS													
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? ANILABLE PRIOR TO COMPLETION DP CAUSE													
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Ξ.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO NO NO NO NO NO NO NO NO NO NO NO NO													
PHYSICIAN:	25. WAS CASE REFERREO TO MEDICAL 26. PLACE DF OEATH (Check only one)													
Sic	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetiant 2 EF	VOutpatient 3	□ DOA	OTHER: 4 Nursing H			6 NOther (Spi			142	1 8 12/19		
并	27. MANNER OF DEATH	28a. DATE OF INJ (Month, Day,		28b. TIM		NJURY AT		28d. DESCRIE		JURY OC	UREO			
ВУ	1 Natural 5 Pending 2 Accident Investigation		,			YES 2	☐ ND							
	3 Suicide 8 Could not be 4 Homicide datarmined	3 Suicide 8 Could not be 28a. PLACE DF INJURY — At home, term, building, atc. (Specify)					, street, factory, office 28t. LOCATION (St City or Town, S					Street and Number or Rural Route Number, State)		
COMPLETED	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and menner as stated.													
00	MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.													
BE	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year)								(Month, Day, Year)					
<u>و</u>	30. NAME AND AGORESS DECERSON WHO	COMPLETED PALIES	E OFATH ATTEN	27) /5	Print)	101	28	19		12	Co =	1795		
	MADNES VM	LEMID.	107	0/	TRAF	TON	DR,	LARG	0	MD	20	772		
	FEB 03 1995													



	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending any many controlled by the hospital or attending any many controlled to the second controlled to the cont	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnial		
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	TENE	10H	after (28 18
	DR A	DIREC	hours	tem
	PITAL	ERAL	I 72 I	
	HOS	FUN	with	RTAN
	THE	THE	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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Kue Kin Wun

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216 High St.,

32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall

	Items 10a thur 10f,	g-722, 4-18	-95, per	f.h.,	dk				9	J	14013
	FOR STATE REGISTRAR	STATE OF MA	ARYLAND /	DEPAR	TMENT OF	HEALTH DEAT	AND I	MENTAL HYGIEI			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH			3. TIME OF DEATH
	Celeste	Gould Hin	ton					MONTH I	AY Q 7	995	2:00 p.m.
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last	birthday)	IF UNDER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH	5 [PLACE (State or Foreign
	095-18-7999	1 M 2 X F	82	YRS.	MONTHS DAYS	HOURS	MIN.	(Month, Day, Year)	012	Countr	y)
	9a. FACILITY NAME (If not institution, give st	met and number)			9b. CITY, TOWN	OR LOCATIO	ON OF DE	Aug.14,1		PA NTY OF D	F 4714
DIRECTOR	At her home				Milli					nt	EAIR
EC	10a. STATE 10b. COUNTY			10c, CIT	Y, TOWN OR LOCA	TION					10d. INSIDE CITY
H	MD PA. Ken	MD pa Kent				⊖n ⊸Phi	Lada	lahia	LIMITS?		
	10e. STREET AND NUMBER						_	Thura		1) YES 2-X NO	
RA	E. Route #291			101, ZIP CODE						/HAT COUNTRY?	
¥		2000					19130-1420		U.S.	Α.	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced				It yes, s		n, Maxica				- American Indian, k, White, atc.
	15. DECEDENT'S EDUC	ATION	18a DEC	ECEPENTIS USUAL COCUPATION				401 1/11/2 05 21		•	
COMPLETED	(Specify only highest grade	completed)	(Gh	ECEDENT'S USUAL OCCUPATION Give kind of work done during most of working Do NOT use retired.)			16b, KIND OF BUSINESS/INDUSTRY				
2	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+		Teacher				Dut	olic	Caha	-1
M	17, FATHER'S NAME (First, Middle, Lest)			Teac	iici					20110	01
	James F. Gould	4						ME (First, Middle, Maider			
BE								e V. Rawl			
5	198. INFORMANT'S NAME (Type/Print) Emma A. Minott 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6042A Catherine Street, Philadelphia, PA 19143										
	20a. METHOD OF DISPOSITION	uni from State	20b. PLACE A	ND DATE	OF DISPOSITION (A			DATE 20c. LO			
	1 M Burlel 2 Cremetion 3 Ramoval from State 4 Donation 5 Other (Specify) Anth Wood Cemetery 1/26/95 Philadelphia PA										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY										
- }	Chestertown, MD 21620										
	23. PART I. Enter the diseases, or complicatione that caused the deeth. Do not enter the mode of dying, such as cerdiec or reepiratory erreet, ehock, or heart failure. Liet only one cause on each line.										
	Intervel Detwee								Intervel Between Onset and Death		
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.										
-	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS										
PHYSICIAN: MEDICAL	Dalcholism & Sevile Dementia 1 YES 2 1 YES 2 1 THE							AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
=	DID TOBACCO USE CONTR	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									1 123 2 110
¥	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH TES INO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
2	EXAMMER? HOSPITAL: OTHER:										
₹	27. MANNER OF DEATH						eldenca	6 Other (Specify)			
ву Рн	1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 YES 2 NO					28d. DESCRIBE HOW INJURY OCCURED				
	3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)						281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) end menner as stated. MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner as stated.										
Ŭ U	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICE					(Month, Day, Year)
TO BE	[[1]. When	n, m					13/		▶ /	/20	195
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (ITEM	27) (Type.	Print)						

Chestertown, MD 21620

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IN FOLDS	death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	e marked as item 22 shows say Inline as other traumstic meant the madical avantages must be excitized at severe
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	FOR STATE REGISTRAR	STATE OF MARYL			HEALTH AND	MENTAL HYGI		
	1. DECEDENT'S NAME (First, Middle, Last) 4. SOCIAL SECURITY NUMBER	Mildred	Hop In yrs. last birthday)	Kins IF UNDER 1 YEA	R F UNDER 24 HRS		ry 15	3. TIME OF OEATH 199.5 8. BIRTHPLACE (State or Foreign
	216-38-9701	1 M 2 XX F	88 YRS.	MONTHS DAY	S HOURS MIN.	February 5	, 1906	Pennsylvania
TOR	9a. FACILITY NAME (If not institution, give Harford Memoria) RESIDENCE OF DECEDENT				n or Location of de Grac			ford
DIRECTOR	10a. STATE 10b. COUNT	ry	10c. CIT	Y, TOWN OR LO	CATION			10d. INSIDE CITY LIMITS?
	Maryland 100. STREET AND NUMBER	Harford		Aberdee	10t, ZIP CODE		100 00	1 YES 2 NO
FUNERAL	118 New County F	toad			21001		log. Ci	U.S.A.
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 _ YES IF YES, GIVE WAR OR DO	2 XNO	If yes	specify Cuban, Max	PANIC ORIGIN? (Specify icen, Puarto Rican, etc.)	Yas or No-	14. RACE — American Indian, Black, White, etc. Specify:
	15. DECEDENT'S ED (Specify only highest grad		16a. DECEDENT'S (Give kind of	work done during	ATION most of working	16b. KIND OF	BUSINESS/IN	White White
PLET	Elementary/Secondery (0-12) 11 yrs.	College (1-4 or 5+)	lite. Do NOT u.	se retired.)		Don	estic	
COMPL	17. FATHER'S NAME (First, Middle, Last)	D				NAME (First, Middle, Main	len Sumame)	
M M	John Francis Mac	Donald	19h MAILING	ADDRESS (Street		e B. Redmi		The Control
2	Norman Hopkins,	Jr.		County		erdeen, Mary		10 1.72
	20a_METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Red 4 Donation 5 Other (Specify)	noval from State	PLACE AND DATE				LOCATION -	- City or Town, Stata on, Maryland
	21. SIGNATURE OF FUNERAL SERVICE VIII I AM L. K	ing, Jr	9.	Fe11	AND ADDRESS OF OWS - We.	11s Funera	1 Hom	es Marvland 21620
PHYSICIAN: MEDICAL CERTIFICATION	23. PART I. Enter the diseases, or abock, or haart failure immediate CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions. DID TOBACCO USE CONTEXT IN TOBACCO USE CONTEXT	a. VOUR TO KOR AS A b. DUE TO KOR AS A d. S DOUE TO COR AS A d. S DOUE TO COR AS A HOSPITAL: 1 Inpetient 2 ER/OUTE 28e. DATE OF INJUNT	CONSEQUENCE OF CONSEQUENCE OF THE PEATH YES CONSEQUENCE OF DEATH SECONDARY S	File J File J	Acce farling cause given UNCERTA	Later Feer In Part I. 24a. WAS PERI	AN AUTOPSY FORMED? 2 MG	Interval Between Onset and Death A Dea
SY P	1 Haturel 5 Pending	(Month, Day, Year)		JURY	WORK?	28d. DESCRIBE HO	W INJURY O	CCURED
- 11	2 Accident 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, atc. (Spec	ily)	A STORY	ffice	281. LOCATION (Stre City or Town, St.	et and Numbe ste)	er or Rural Route Number,
COMPLEIED	i 1	SICIAN: To the best of my knowl ER: On the basis of exemination						ated. the ceuse(s) and manner as stated.
10 BE C	29b. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON W	NO	ATH (ITEM 27) (Type	, Print)	29c. LICENSE N	UMBER 3	29d. DA	ITE SIGNED (Month, Day, Year)
	31. DATE FILED (MOTHE, Day Year)	DV MA SMARRSISIGN Way door	AME L		1)	f CRWS	r. 3	Moerkeen, MIL

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DIVISION OF VITAL RECORDS, P.O. BOX 58/50,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hou	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the m
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Page 6 may be retained by the

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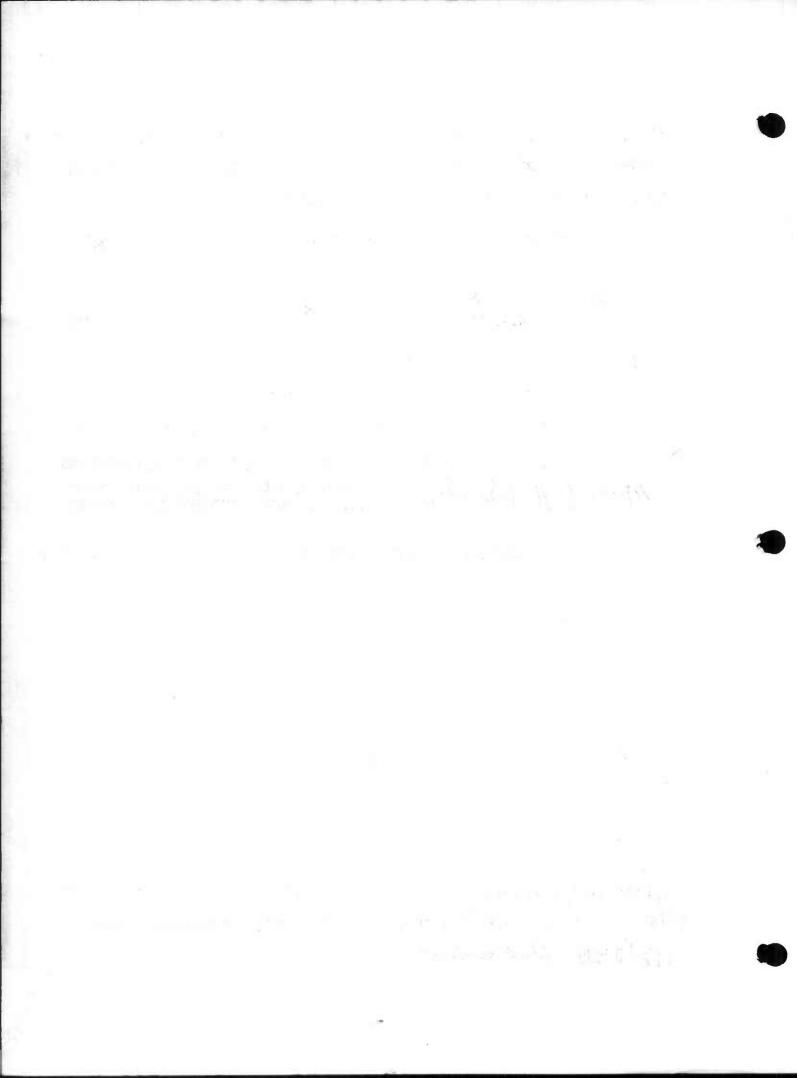
STATE TREGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S HAME (First, Middle, Last) 2. DATE OF DEATH January 1995 Gladys Hullings 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTY 8. BIRTHPLACE (State or Foreig Country) 1 - M 2 X F DAYS HOURS YRS. 578-12-1486 April 5,1905 Washington, D.C. 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Southern Maryland Hospital Conter Princ DIRECTOR lintor Georges 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Charles Waldorf 1 XYES 2 HO 10e. STREET AHD HUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEH OF WHAT COUHTRY? 321 Bucknell Circle 20602 U.S.A. 11 MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 100 O IF YES, GIVE WAR OR DATES 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No—II yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 HO Specify: 14. RACE — American Indian, Black, White, alc. 1 Never Married 2 Married Specify: White BY 3 X Widowed 4 Divorced COMPLETED 15. OECEDENT'S EDUCATION 16a. DECEOENT'S USUAL OCCUPATION 16b, KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker At Home 6 17. FATHER'S HAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Herman J. Buscher Gertrude V. Waltermeyer 品 19a. IHFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Beverly Breen Bucknell Circle, Waldorf, Maryland 20602 20a, METHOD OF DISPOSITION

| X | X | Burlal | 2 | Cremation | 3 | Ramoval Irom State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State cemetery, cremetory or other place)
Cedar Hill Cemetery Donation /5 - Other (Specify) 1/31/95 Suitland, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. HAME AHD ADDRESS DF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md.20745 23. PART I. Enter the shock, or diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximata Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition monary hrs reaulting in daath) DUE TO (OR AS A COHSEQUENCE OF): dio gen CERTIFICATION Sequantially flat conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST TRS PART II. Other algorificant conditions contributing to death but not reaulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL 24a. WAS AH AUTOPSY PERFORMED? tusion COMPLETION DF CAUSE 1 - YES 2 1 HO DF OEATH? 1 ☐ YES 2 😿 HO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF OEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO 1 M Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANHER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. IHJURY AT 28d, DESCRIBE HOW IHJURY OCCURED 1 | Hatural 1 YES 2 HO м BY Investigation 2 Accident 28a. PLACE OF IHJURY — At home, Ierm, street, lactory, offica building, aic. (Specify) 3 Sulcide 28I. LOCATIOH (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER 1 💢 CERTIFYING PHYSICIAH: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMIHER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, data and piece, and due to the ceuse(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE HUMBER 29d. DATE SIGNEO (Month, Day, Year) 띪 9646 2 HAME AHO AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) Sei 3600 32. REGISTRAR'S SIGNATURE JAN 3 0 1995 Julia Davideor Re

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	y the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tra	nd Mental Hygiene prior to burial, cremation, or removal.	
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT			MENT	AL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DAT	TE OF DEATH		3	. TIME OF DE	ATH
	CHARLES T		RSHEY					RUARY 5		YEAR 5	8:38	P M
	213-03-1196	M2□F 84	In yrs. lest birthday	MONTHE		IF UNDER 24 HRS, HOURS MIN,	APR	TE OF BIRTH Inth, Day, Year) IL 16,1	910		ACE (State or YLAND	Foreign
OR	9a. FACILITY NAME (If not institution, give street WILSON HEALTH CARE					RSBURG	EATH		9c. COUNT	TGOM		
	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. C	TTY, TOWN OF	R LOCATIO	N				11	Od. INSIDE CI	TY
FUNERAL DIRECTOR	MARYLAND MONTGO	MERY		GAITHE	RSBU	RG				1	LIMITS? YES 2	
RAL	10e. STREET AND NUMBER	-			101. Z	IP CODE			-		AT COUNTRY	7
N.	8 RED KILN COUR	WAS DECEDENT EVER IN	III S ADMED	49.14	TA DECEM	2087	_				TATES	
B⊀	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 NO	11	yes, speci	fy Cuban, Maxic	an, Puert	GIN7 (Specify Yea o Rican, etc.)	or No 1	Specify:	- American in White, atc.	dian,
밀	15. DECEDENT'S EDUCATION (Specify only highest grade company)	ON pleted)	16a. DECEDENT	of work done di	CUPATION uring most of	of working	1	66. KIND OF BUS	INESS/INDU		MILLIE	
COMPLETED	Elementary/Secondary (0-12) Co	ollege (1-4 or 5 +)		use retired.) -OPERA	TOR			REST	AURAN'	Т		
	17. FATHER'S NAME (First, Middle, Last) DAVID HERSHE	Υ			1	a MOTHER'S NA		t, Middle, Maiden :	Sumame)			
TO BE	19a. INFORMANT'S NAME (Type/Print)					Number or Rural	Route Nu	mber, City or Town	n, State, Zip C	,		
	DORIS P. HERSHEY	206	8 REI	O KILN				RSBURG,	MARYLATION — CI		20878	
	1 Burisi 2 Cremation 3 Removal 4 Donation 5 Other (Specify)		ARKLAWI				2/				RYLAND	
	21. SIGNATURE OF FUNERAL SERVICE LICENS MULLIST H	- Bark	er	MU	RIEL		RBER	FUNERA AYTONSV	L HOM	E :	20882	
	23. PART I. Enter the diseases, or compandock, or heart failure. List	plications that caused	tha death. Do	not entar t	the moda	of dying, aud	ch ss ca	irdiac or respir	ratory srres	it,	Approxi	
	IMMEDIATE CAUSE (Final disease or condition			0.40	CTNO						Onset a	Batween nd Death
	resulting in death) a	METASTATIO			CINO	MA					ONE Y	EAR
NO	Sequentially list conditions,	205 72 62 44		-								
CATI	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A	CONSEQUENCE	OF):								
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE	OF):								
	d	and the sale of the t								_	<u> </u>	
CAL	PART II. Other algnificant conditions co	ontributing to death bi	ut not resulting	j in tha und	derlying c	ause given in	Part I.	24s. WAS AN / PERFORI	MED?	A	ERE AUTOPSY MILABLE PRIO OMPLETION OF	R TO
PHYSICIAN: MEDIC								1 TYES 2	XNO	Di	F DEATH?	
N.											0 199	
SIC!		DSPITAL:	etleet 3 DOA	OTHER	:	E OF DEATH (C)						
품	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b, T		28c. INJUR WORK		7	eş (Specify)	JURY OCCU	RED		-
ВУ	T Natural 5 Pending 2 Accident Investigation			М	1 YES	2 NO						
TED	3 Suicide 8 Could not be 4 Homicide datarmined	28s. PLACE OF INJURY building, etc. (Speci	— At nome, term	, atreet, lacto	ry, office		281. LC	CATION (Street as ty or Town, State)	nd Number or	Rural Rou	te Number,	
COMPLETED	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN EXAMINER: Or MEDICAL EXAMINER: Or											
	29b. SIGNATURE AND JUTLE OF CERTIFIER		- Investigation	tion, in my op		9c. LICENSE NUI		na and piece, and				
TO BE	30. NAME AND ADDRESS OF PERSON WHO CO	hun))			D13977	mildia M				onth, Day, Yea Y 6,19	
	ROBERT MILLMAN M.D		OICAL CE		DRIVI	E ROCK	(VILI	LE,MARY	LAND	2085	50	
	31. DATE FILED (Month, Dey, Year)	32. REGISTRAR'S SIGNA	TURE									
	FB = 9 1999 3d	w to snartor NV	Mall								DUM	16 Rev 1/89



n signed by the attending physician and completely filled in by the funeral director, page 5 social by defeathed for use as the burst	removal	And the second section of the second section is the second section of the second section is the second section in the second section is the second section in the second section is the second section in the second section is the second section in the second section is the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section is the second section in the second section is the second section in the second section is the second section in the second section is the second section in the second section is the second section in the second section is the second section in the second section is the second section in the second section is the second section in the second section is the second section in the second section is the second section in the second section is the second section in the second section is the second section in the second section is the second section in the second section is the second section in the second section in the second section is the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section is the second section in the second section in the section is the section in the section is the section in the section is the section in the section is the section in the section is the section in the section is the section in the section is the section in the section is the section in the section is the section in the section is the section in the section is the section in the section is the section in the section is the section in th
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OR: After this certificate has been signed by the attending physician and completely filled in	ind Mental Hygiene prior to burial, cremativ	the factor of the state of the same and
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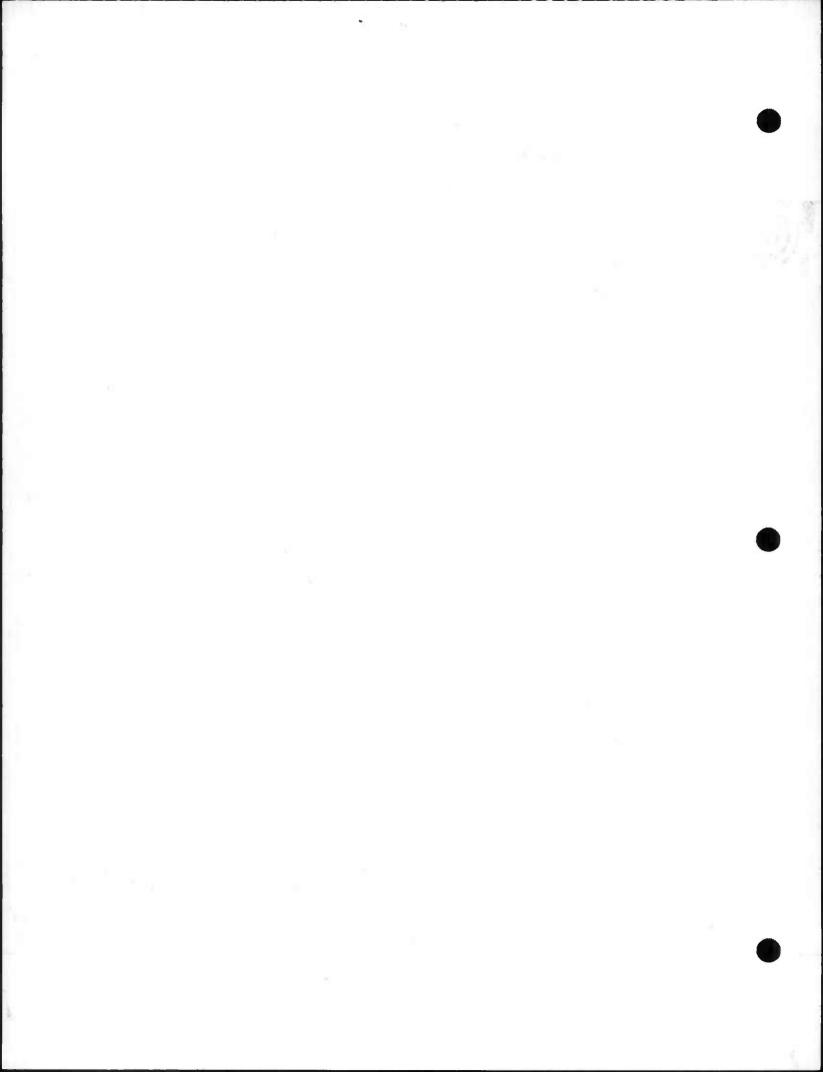
HARRY P.
31. OATE FILED (MONTH, Day, Ybar)

JAN 18 '95

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32. REGISTRAR'S SIGNATURE lia Davidson-Randelle

FOR 1 - STATE REGISTRAR	STATE OF MARYLAND /	DEPARTMENT OF HEALTH AND ERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.	
1. DECEDENT'S NAME (First, Middle, La:			2. DATE OF DEATH	3. TIME OF OEATH
Harol	d Bovd	Hill	January 12	1995 9:00 A
4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. las	st birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign
215-32-205	81XH2 0 F 67	7 YRS. MONTHS DAYS HOURS MIN.	(Month, Day, Year)	MARYIANT
9a. FACILITY NAME (If not institution, given		9b. CITY, TOWN OR LOCATION OF		ONTY OF DEATH
The Kent and Que	en Anne's Hospita	l,In¢. Chestertow	ın K	ent
10a. STATE 10b. COU	4 4	10c. CITY, TOWH OR LOCATION		10d. INSIDE CITY LIMITS?
	KENT	1 ROCK HAL	L	1 YES 2 NO
10e. STREET AND NUMBER 11. MARITAL STATUS 1 Never Married 2 Married	Bay 200	10f. ZIP CODE	10g. CI	TIZEN OF WHAT COUNTRY?
11. MARITAL STATUS	BOX 208	2	661	USA
	FORCES? 1 YES 2	NO II yes, specify Cuben, Mexic		14. RACE — American Indian, Black, White, atc.
3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	1 TYES 2 NO Spec	tty:	Specify: WHITE
(Specify only highest on Elementary/Secondary (0-12) TH GR. 17. FATHER'S NAME (First, Middle, Last)	DUCATION 18a. DE	CEDENT'S USUAL OCCUPATION	16b. KIND OF BUSINESS/IN	IDUSTRY
Elementary/Secondary (0-12)		ive kind of work done during most of working b. Do NOT use retired.)	Λ	
6THGR.		FARMER	AGRICU	ILTURE
17. FATHER'S NAME (First, Middle, Last)	11:	18. MOTHER'S N	AME (First, Middle, Maiden Surname)	1
HERMA	N MILL	RE	BECCA L	SONNEY
19a. INFORMANT'S NAME (Type/Print)	10 - 11:41	b. MAILING ADDRESS (Street and Number or Rure	Route Number, City or Town, State, 2	(ip Code)
11/2, 71/1	SICE DILL	P.O. Box 208	TOCKHALL	MD 21661
20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Re 4 Donation 5 Other (Specify)	emoval from State 20b. PLACE.	AND DATE OF DISPOSITION (Name of	OAT 20c. LOCATION -	- City or Town, Stata
	The second secon	SLEY CHAPEL	115 ROCK	CHALL ME
21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	22. NAME AND ADDRESS OF F	BEIN FUNE	RAL HOME
Jack A	telentein	130 SPEER	-D 0	ESTERTOWN
23. PART I. Enter the dieeeses, o	r complications that caused the de	eth. Do not enter the mode of dying, su		rrest, Approximate
iMMEDIATE CAUSE (Finel	e. List only one cause on each line		/	interval Batween
disease or condition resulting in death)	Mar	mire stress	10 and	26 day C
resulting in death)	OUE TO (OR AS A CONSE	QUENCE OF):	1	7 4000/)
2	· Coror	ran anlesse	useari	year
Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSE	OUENCE OF):	2	
CAUSE (Disease or injury	a seulia	Ged ASCV	<i>'</i>	years
thet initieted events resulting in death) LAST	OUE TO IOR AS A CONSE	QUE OF):		
iii doddii EASI	d			
PART ii. Other significant conditi	ons contributing to/deeth but not a	resulting in the underlying cause given in	Part i. 24s. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
PARI II. Other significant conditions of the con	nan Tart	wife tim à	PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
	relite Das	1 Bennin	1 D YES 2 NO	OF DEATH?
	TRIBUTE TO CAUSE OF DEA	TH YES NO UNCERTA		1 NES 2 NO
25. WAS CASE REFERRED TO MEDICAL		CE OF DEATH (Check only one)		
EXAMINER?	HOSPITAL: 1 Department 2 ER/Outpatient 3	OTHER:	• C • C • C • C • C • C • C • C • C • C	
DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 HO 27. MANNER OF WEATH	28a. DATE OF INJURY	28b. TIME OF 28c, INJURY AT	28d. OESCRIBE HOW INJURY OF	CCURED
III I/ NINITURE 3 Pendina	(Month, Day, Year)	INJURY WORK? M 1 Tyes 2 No		
2 Accident Investigation 3 Suicide a Could not be	28s. PLACE OF INJURY - At ho		281. LOCATION (Street and Number	er or Rural Route Number,
U 4 Homicide determined	 building, atc. (Specify) 		City or Town, State)	
290. CERTIFIER 1 CERTIFYING PH	SICIAN: To the best of my knowledge de-	eath occurred at the time, data and place, and du	a to the cause(a) and manner	-124
		investigation, in my opinion, death occured at ih		
III 20h SIGNATURE AND TITLE BE CERTIE				
m 23d. Sidnaibhe and Tilee of Centil	- Vand 111	ff MA) 29c. LICENSE NU	() () () () () () () () () () () () () (TE SIGNEO Month, Day, Year)
30. NAME AND ADDRESS OF PERSON V	VHC COMPLETED CAUSE OF DEATH (ITE	M 27) (Time Print)	100/	6 Jun 1/11



3. TIME OF DEATH

2. DATE OF DEATH

DAY 195 28, EUGENE JOSEPH HENRY SR. 0920 JANUARY 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPI ACE (State or Formion County, 2-4-1 212-07-8011 77 1 M 2 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH WORCESTER 13906 FOUNTAIN RD. OCEAN CITY DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10e STATE 10c CITY TOWN OR LOCATION 10d. INSIDE CITY MD. OCEAN CITY WORCESTER 1 YES 2 NO FUNERAL 10a, STREET AND NUMBER 101. ZIP CODE 21842 USA 13906 FOUNTAIN RD. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ☐ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried Specify: 3 Widowed 4 Divorced WHITE BALTIMORE, MARYLAND 21215 16e. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) atte 15. DECEDENT'S EOUCATION 16b. KIND OF BUSINESS/INDUSTRY use COMPLET retained by the hospital or for College (1-4 or 5 +) SOCIAL SERVICES STATE GOVERNMENT funeral director, page 5 should be detached 17. FATHER'S NAME (First, Middle, Last) 18, MOTHER'S NAME (First, Middle, Maiden Surname) WILLIAM J. HENRY to ANNA DILL BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ACORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 13906 FOUNTAIN RD. 21842 DORIS G. HENRY OCEAN CITY, MD. eq 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must 1 Burlel 2 Cremetion 3 5 4 Donation 5 Other (Specify) CREMATORY 1 - 30ISRURY SAL ISBURY, MD medical examiner 21. SIGNATURE OF ULLRICH FUNERAL HOME MD. BERLIN, filled in by the fu 23. PARTUEnter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, Approximate ahock, or heart failure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final **Onset and Death** signed by the attending physician and completely fille Health and Mental Hygiene prior to bunal, cremation, the disesse or condition_ YNOSTATE ETASTANC reculting in death) event. DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST any injury, PART il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 1 YES 2 ZNO OF DEATH? Shows 1 | YES 2 | NO this certificate has been with the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OR ATTENDING PHYSICIAN: The **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 4NO 1 Inpatient 2 ER/Outpatient 3 DOA me 5 Rasidence 6 Other (Specify) 6 26e. DATE OF INJURY (Month, Day, Year) 27. MANNEB OF DEATH 28c. INJURY AT WORK?
1 YES 2 NO 28b. TIME OF INJURY 26d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural 5 Pending BY After 2 Accident Investigation 26e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is DIRECTOR: A COMPLETED TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Item 2 29a. CERTIFIER 1 DERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data end placa, and due to the cause(a) and manner as stated. mination and/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(a) and n ATURE AND TITLE OF CERTIFIER NEO (Mo Day Men BE 9 AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF CHAFT (NEM 27) (Type, EN. NOSP. 218/1 31. DATE FILED, (Month, Day, Year) 32. REGISTRAR'S 1995

whi Dendem Re

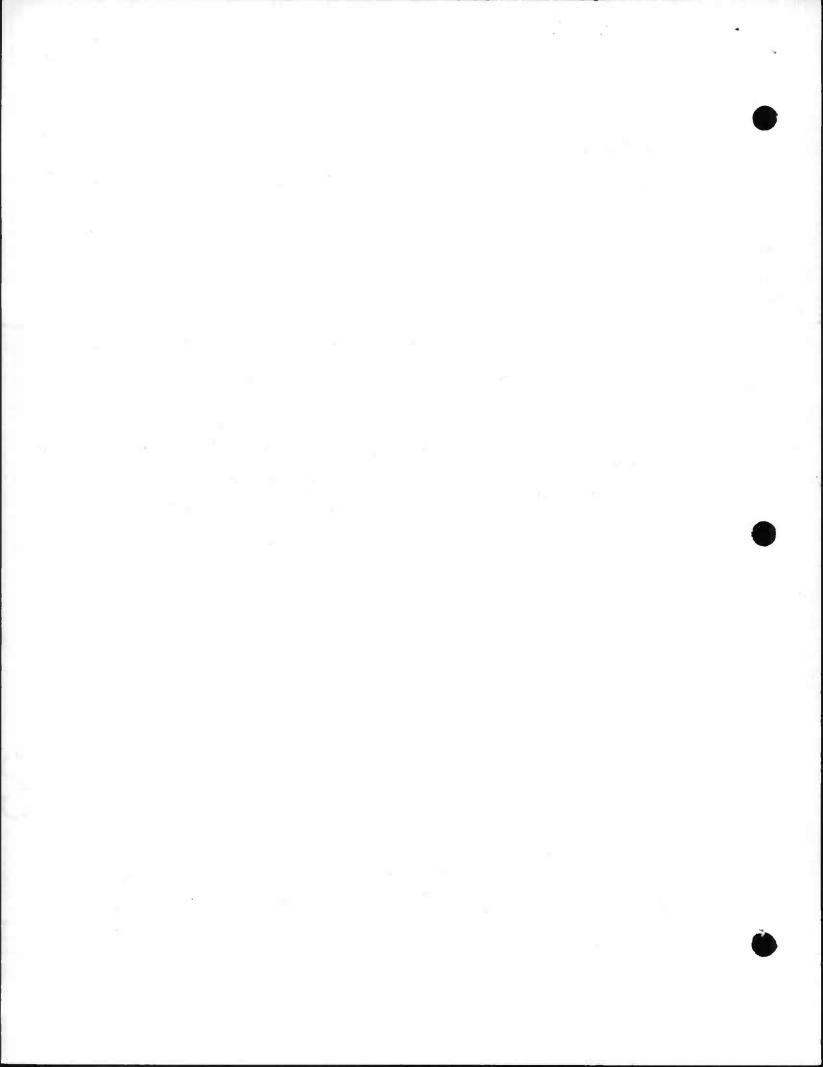
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

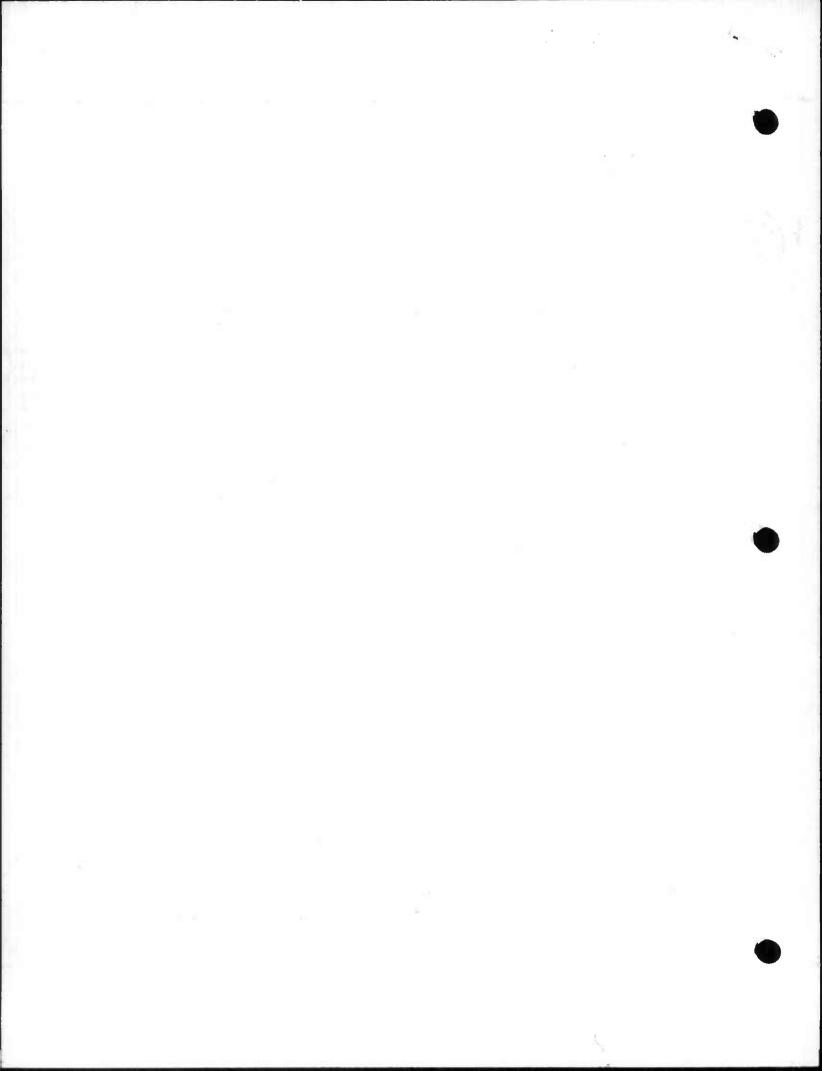
STATE REGISTRAR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1. DECEDENT'S NAME (First, Middle, Last)



DIVISION OF VITAL RECORDS, P.O. BOX 68760



PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	r this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans	
death. Page 6 may	funeral director, pa	
nours after	lled in by the	Or removal
ecuted wit	nd completery if	unial cremation
certificate be exe	ding physician ar	h with the State Dant of Health and Mental Horison prior to burial cremation or removal
that the death	ed by the atter	th and Mental
e law requires	has been sign	Dant of Heat
PHYSICIAN: Th	this certificate	with the State

DIVISION OF VITAL RECORDS, P.O. BOX 6876.

BALTIMORE, MARYLAND 21215-0020

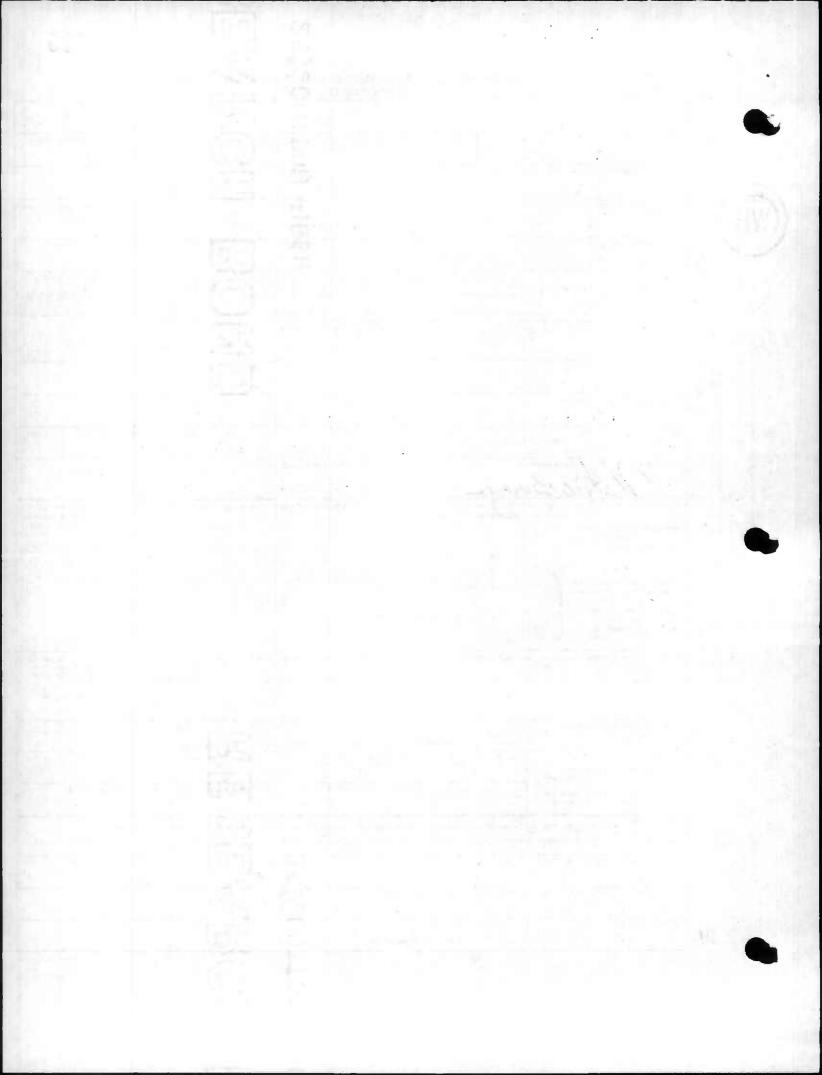
	1. OECEDENT'S NAME (First, Middle, Lest)	2				DEATH	2. DATE	REG. NO.			. TIME OF D	АТН
	Burton Dale H	eckman,	Jr.				MONT			EAR	7:30	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. last	t birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		OF BIRTH		BIRTHPI	LACE (State of	-
	176-50-0027	1 M 2 - F	39	YRS.	MONTHS DAYS	HOURS MIN.		14/55		Country)	PA	
	Se. FACILITY NAME (If not institution, give a	street and number)			96. CITY, TOWN O	OR LOCATION OF D			9c. COUNT			_
OR	14002 Barge R	D			0.	cean Cit	У		Wo	rces	ter	
DIRECTOR	10a. STATE 10b. COUNT WO	rcester			ry, town on Locat						0d. INSIDE C	
	10e. STREET AND NUMBER					I. ZIP CODE			10- 0/7/75		YES 2	_
RA	14002 Barge R	D			101	21842		11	US		AT COUNTRY	1
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS OECEDER	NT EVER IN U.S. ARI 1 YES 2 N WAR OR DATES		II yes, sp	CENDENT OF HISPA Healfy Cuban, Mexic is 2 X NO Speci	en, Puerto		or No — 14	Black,	- American le White, etc. White	
ED	15. DECEOENT'S EDU	CATION	16a, DE	CEDENT'S	USUAL OCCUPATION	ON	166	. KIND OF BUSIN	NESS/INDUS	STRY		_
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	Ma	Do NOT u	work done during mo ise retired.)	ost of working						
AP.	12		C	ard	Dealer		4	Casino	S			
COMPL	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S N						
BE (Burton D. Heck	cman, Sr	•			Jeanne	Lah	Rue Mer	rkel			
5	19a. INFORMANT'S NAME (Typo/Print) Burton D. Hecl	cman, Sr			02 Barge					1842		I
	20s. METHOD OF DISPOSITION		20b. PLACEA		OF DISPOSITION (No		DAT		ATION — CH	y or Town	n, State	_
	4 Donetion 5 Other (Specify)		Suns	et W	iemorial	Park 2	2/2/9	5 Ber	lin, I	MD		
	21. SIGNATURE OF PURE RALES ERVICE LI	Bentae			108	Williams	St.		, MD	21	Home 811	9
Z	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentisity list conditions, if sny, leading to immediate cause. Enter UNDERLYING	s. Oue to	O OR AS A CONSEC	QUENCE O	VA VP):	de of dynig, suc	on se cen	or respira	atory sires		Approx Interval Onset :	Be
TIFICATIO	CAUSE (Disease or Injury that initiated eventa resulting in death) LAST											_
CERTIFICATIO		d										_
: MEDICAL CERTIFICATION	that initiated events	d	o deeth but not n	eeulting	in the underlyin	g cause given in	Part i.	24a. WAS AN AI PERFORM 1 YES 2 §	ED?	6	VERE AUTOPS: WAILABLE PRICOMPLETION COMPLETION COF DEATH? YES 2	FC
MEDICAL	that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL	d	o deeth but no1 n	eeulting		g cause given in		PERFORM 1 VES 2 5	ED?	6	WAILABLE PRI COMPLETION (OF DEATH?	FC
SICIAN: MEDICAL	that initiated events resulting in death) LAST PART II. Other significant condition	HOSPITAL:	o deeth but not n		26. PI	LACE OF DEATH (C	heck only o	PERFORM 1 YES 2 5	ED?	6	WAILABLE PRI COMPLETION (OF DEATH?	FC
PHYSICIAN: MEDICAL	PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural S Pending	HOSPITAL: 1 Inpatient 2	□ ER/Outpatient 3	□ DOA	26. PI OTHER: 4 Nursing Horr WE OF 28c. INJ		heck only of	PERFORM 1 YES 2 5	NO	1	WAILABLE PRI COMPLETION (OF DEATH?	FC
SICIAN: MEDICAL	PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural S Pending	HOSPITAL: 1 inpatient 2 28e. DATEO (Month, 1) 28e. PLACE	□ ER/Outpatient 3 F INJURY Day: Year)	DOA 28b, TIN	26. PI OTHER: 4 Nursing Horr WE OF 28c. INJ	LACE OF DEATH (Come 5 Realdence JURY AT PRK?	heck only of	PERFORM 1 VES 2 5	NO NO	A C C C C C C C C C C C C C C C C C C C	WAILABLE PRI COMPLETION OF DEATH?	FO

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1995

32. REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Year)
FEB 02



FOR 1 - STATE REGISTRAR	STATE OF P	MARYLAND /	DEPART ERTIFIC	MENT O	F HI	EALTH DE A	AND I	MENTA	L HYGIEN			
1. OECEOENT'S NAME (First, Middle, Last)					-			2 DATE	OF DEATH			a THE OF OCCUPA
	frey	Higgins	_	milte	011			MONT		Õ, 19	995	3. TIME OF OEATH
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs la:	"	IF UNDER 1 YE	_	IF UNDER		7. DATE	OF BIRTH		6. BIRTH	PLACE (State or Foreign
219-70-9082	1X M 2 □ F	32 3	YRS.	ONTHS DA	AY8	HOURS	MIN.	June	27,	1963	Mar	vland
9e. FACILITY NAME (If not institution, give at	treet and number)		- 1	b. CITY, TO	WN OF	LOCATI	ON OF DE			1	NTY OF DI	*
27203 Ri	gbylot F	Road		Eas	ton	, Ma	aryla	and		Man	rylan	id Talbot
10e. STATE 10b. COUNTY	,		10c, CITY,	TOWN OR L	OCATIO	ON						10d. INSIDE CITY
Louisiana			New	Orle	ans	777						LIMITS? YES 2 NO
10e. STREET AND NUMBER					10f.	ZIP COD	E			10g. CIT	IZEN OF W	HAT COUNTRY?
508 Bar	racks St	reet				7013	16			Г	JSA	
11. MARITAL STATUS	12. WAS DECEOEN	T EVER IN U.S. AF	MED	13. WAS	OECE	NDENT C	F HISPAN	IIC ORIGIN	7 (Specify Yes		14. RACE	- American Indian,
1 Never Merried 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE W	YES 2 X	NO				Specify		tican, atc.)		Specif	White, atc.
15. DECEDENT'S EDUC (Specify only highest grade	CATION	16a. DE	CEDENT'S US	SUAL OCCU	PATION	4		16b.	KIND OF BUS	SINESS/INI	DUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5	iffe	ive kind of wor Do NOT use i	retired.)	ng most	or working	ng					
12	4	Re	estaur	ant n	ກສເາ	ager	•		Food			
17. FATHER'S NAME (First, Middle, Last)								ME (First, A	Aiddle, Maiden	Surneme)		
James H. Ha	milton								Reicha			
19s. INFORMANT'S NAME (Type/Print)		19	b. MAILING A	DDRESS (Str	reet en				er, City or Tow		Code	
James H. Hamilto	n		P. O.						haels			663
20e. METHOD OF DISPOSITION 1 ☐ Buriel 2 X Cremetion 3 ☐ Remo	wal from State		ANDDATEOF		N (Nam	e of		OATI			City or Tox	
4 Donation 5 Dother (Specify)	THE STATE OF THE S	- Capito	ol Cre	mator	T		1/3	1/95	Des	70r	Dela	ພາດກວ
21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22. NAM	E AND		SS OF FAC	CILITY	100	3.5	mieni e	Wair 6
Darison E	Les	main	1	Harr	ris	on E	Le	onar	d Fune	eral	Home	T. 01.000
23. PART I. Enter the disesses, or c	omplications the	t caused the de	eth. Do not	enter the	mod	e of dyl	ng, auch	aa cerd	lac or reapi	ratory an	rest.	Approximats
shock, or heert failure. I IMMEDIATE CAUSE (Finst	lat only one ceu	se on each line).									interval Bstween
disesse or condition	177	0	1100	رم ا	0							Onset and Death
resulting in death)	OUE TO	(OF AS A CONSE	DUENCE OF):	101	~							
_		TO COMPE	DOLINCE OF).									
Sequentially list conditions,	DUE TO	(OR AS A CONSEC	DUENCE OF									
if any, leading to immediate cause. Enter UNDERLYING		(,									ĺ
CAUSE (Disease or Injury that initiated events	OUE TO	(OR AS A CONSEC	DITENCE OF									-
resulting in death) LAST		(
	•											
PART II. Other algnificent conditions	contributing to	deeth but not r	eeulting in	the under	lying	ceuse g	lven in i	Part I.	24a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
									PERFOR	14		AVAILABLE PRIOR TO COMPLETION OF CAUSE
								- 1	1 TYES 2	MINO		OF DEATH?
								-				1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL												
EXAMINER?	HOSPITAL:		0	THER:	6. PLA	CE OF DI	EATH (Che	ck only one)			
1 MYES 2 □ NO 27. MANNER OF DEATH	1 inpatient 2		DOA 4	☐ Nursing		_	sidence i	B 🗆 Other	(Specify)			
1 Natural 5 Pending	28e. OATE OF (Month, De		28b. TIME C	Y	NUUN .	K?		28d. DE\$	CRIBE HOW II	NJURY OC	CUREO	
2 Accident Investigation						S 2 [NO					
3 Suicide 8 Could not be determined	28e. PLACE Of building,	F INJURY At ho etc. (Specify)	me, ferm, atre	et, fectory,	office			281. LOCA City o	TION (Street a or Town, State)	nd Number	or Rural Ro	oute Number,
290. CERTIFIER								-		-		
(Check only one) 1 CERTIFYING PHYSIC												
2 MEDICAL EXAMINER	: Un the beele of ex	amination end/or i	investigation, i	in my opinio	on, des	th occur	ed at the t	lime, date	and place, en	d due to th	e Cause(e)	end manner ee stated.
29b. SIGNATURE AND TITLE OF CERTIFIER	0 -				1	29c LICE	NSE NUM	BED		204 DAT	CIONED	Marth Dr. Mart

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit perrol be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Jurs after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

TO BE COMPLETED BY FUNERAL DIRECTOR

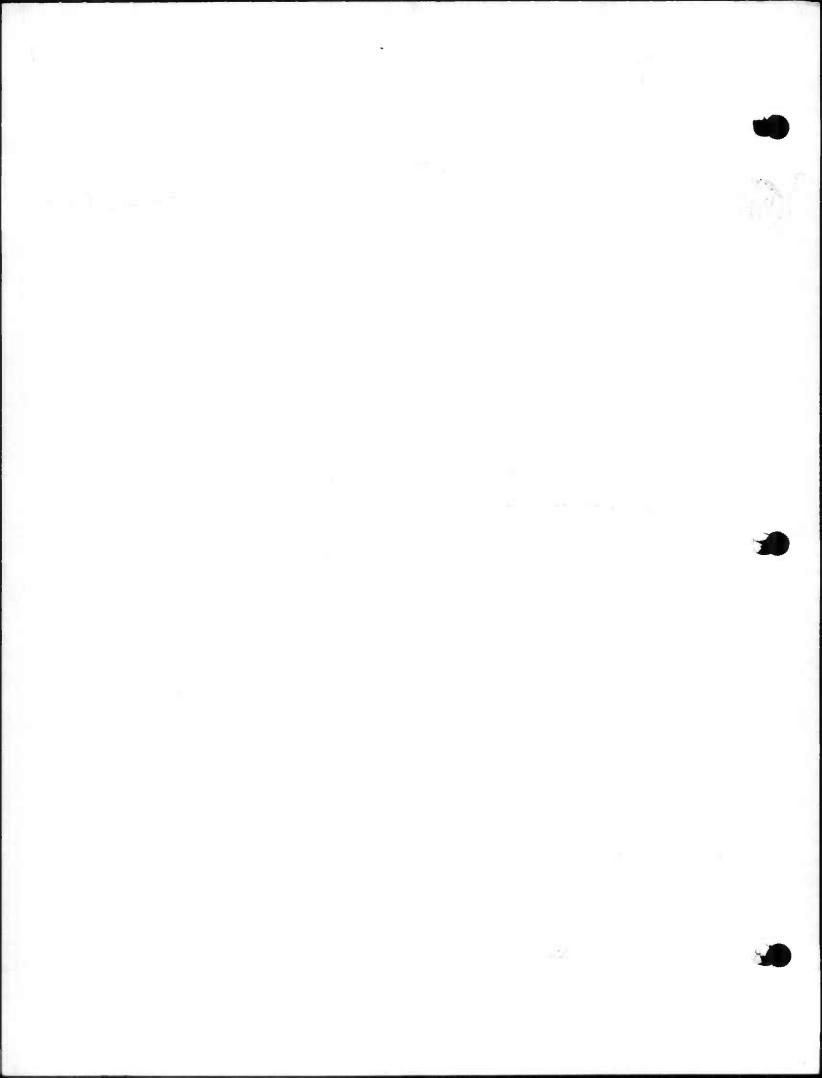
IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

E. Thomas Divilio,
31. DATE FILEO (Morth, Day, Year)
FEB - 2 1995

D. 404 Marvel Ct., Easton, Maryland M.

2



1	STATE REGISTRAR
	_

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Second Second Price (Associated Second Second Price (Associated Second Second Price (Associated Second Second Price (Associated Second Second Price (Associated Second Second Price (Associated Second Second Price (Associated Second Second Price (Associated Second Second Price (Associated Second Second Price (Associated Second Second Price (Associated Second Second Price (Associated Second Price (As	1 - STATE REGISTRAR	OTHE OF HIMIT	CERTIFIC	ATE OF	DEATH	REG. NO.	-	
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4. SOCIAL PROMET NAME (PART NAME) 2. LEX	Hazel Warfel W	I o o lz					A A	EAR
214 - 38 - 3760 1			iE (In vrs. last birthday)	FUNDER 1 YEAR	IF LINDER 24 HRS		I a	
THE RECEIPT AND FUNCTION OF DESCRIPTION OF SECURITY OF PARK SEVERT A PARK SEVERT A PARK AND COUNTY NO. THE SECURCE OF DESCRIPTION HOLD COUNTY NO. THE	214 20 2760		WDG MC			(Month, Day, Year)		Country)
MATY JAIN SEVETIA PATK MATY JAIN SEVETIA PATK SECTION OR LOCATION MATY JAIN AND CODE 100 CETTO TOWN OR LOCATION AND MATY JAIN AND CODE 100 CETTO TOWN OR LOCATION AND MATY JAIN AND CODE 100 CETTO TOWN OR LOCATION		Δ .	93	OUTY TOWN				
THE STREET WAS CONTROLLED TO BE A RECORD TO THE STREET OF THE STREET WAS CONTROLLED TO THE STREET WAS C				b. CITY, TOWN C	OR LOCATION OF DE	EATH	9c. COUNTY	OF DEATH
Mary Anne Anne Arundel Sever na Park 10 or 900 10 or 10	Meridian Nursi	ng Home		Sever	na Park		Anne	Arundel
Maryland Anne Arundel Severna Park 10 Was present Announcer 10 Was present Announcer 10 Was present Announcer 10 Was part 10 Was par		7	10c, CITY, T	DWN OR LOCAT	ION			104 INCIDE OITY
Secretary Secr	Maryland Anno	Amundal		Court Sea 1	1771			LIMITS?
23.5 Wiltshire Lane 11. MARIEL STAVE 12. WAS DECODERT EVER IN US. ARMED 12. WAS DECODERT EVER IN US. ARMED 13. WAS DECODERT OF HERMAC CONSIDERATION OR THE PROPERTY OF THE		Arunuer	sev					
MARTINE STATUS 12 was necessary (19 mg) 12 was necessary (19 mg) 12 was necessary (19 mg) 13 was necessary (19 mg) 14 was necessary (19 mg) 15 wg) 15	, 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	7		101				
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Security 3 Greenwale 3 Greenwale 1 General 3 Greenwale 1 General 3 Greenwale 3 Green			Same	as #	10			
## SCHARTURE OF TUNERAL SERVICE LETEMBE ## JACK OF DEATH STANKE AND ADDRESS OF FACILITY ## BATTAINCO and Sons Funeral Home 4.9.5 Ritchie Hwy Severna Park MD 21146 4.9.5 Ritchie Hwy Severna Park MD 21146 4.9.5 Ritchie Hwy Severna Park MD 21146 4.9.5 Ritchie Hwy Severna Park MD 21146 4.9.5 Ritchie Hwy Severna Park MD 21146 4.9.5 Ritchie Hwy Severna Park MD 21146 4.9.5 Ritchie Hwy Severna Park MD 21146 4.9.5 Ritchie Hwy Severna Park MD 21146 4.9.5 Ritchie Hwy Severna Park MD 21146 4.9.5 Ritchie Hwy Severna Park MD 21146 4.9.5 Ritchie Hwy Severna Park MD 21146 4.9.5 Ritchie Hwy Severna Park MD 21146 5.9.5 Ritchie Hwy Severna Park MD 21146 6.9.5 Ritchie Hwy Severna P					me of	DATE 20c. LO	CATION - CIT	or Town, State
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29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner as stated. 29b. SCHATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year)	a Callette	28s. PLACE OF INJU	RY — At home, farm, stree	nt, factory, office		28f. LOCATION (Street a	nd Number or	Rural Route Number,
(Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. 28th SCHATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER D 2() 7 6 29d. DATE SIGNED (Month, Day, Year) D 2() 7 6 20d. DATE SIGNED (Month, Day, Year) Completed Cause of Death (ITEM 22-1795, Print) SCHA MUNDRA MD 203 C PATALCOA. B MI 1000 MD 21225		building, etc. (Sp	эеспу)		1	City or Town, State)		
2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 20c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 20c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 20c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 20c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 20c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 20c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 20c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)	29a. CERTIFIER	NAM: To the best of an i					10%	
29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Dey, Year) 29d. DATE SIGNED (Month, D								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 22) APPRICE AV. BALLIMORE MP 2/25			inor enuror investigation, l	i my opinion, de	entri occured at the	time, data and placa, and	oue to the c	ause(a) and manner as stated.
SURYA MUNDRA MD 203 E. PATARSEDA, BALTIMORE MD 21225	396. SENATURE AND TITLE OF CERTIFIER	Ma	K1782 - 02702		29c. LICENSE NUM	BER	29d. DATE S	GNED (Month, Day, Year)
SURYA MUNDRA MD 203 E. PATARSEDA, BALTIMORE MD 21225	111102	affella	of Mn		N 51	116	12	6194
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF I	DEATH (ITEM 27)-(1) PE, Pris	nt)			-	-
	JOINTA MOUT	WARA MY	203 E.	PATA	rscot	h, BAC	CIMO	RE MP 21225

ours after death. Page 6 may be retained by the hospital or attending physician. **BALTIMORE, MARYLAND 21215-0020** TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

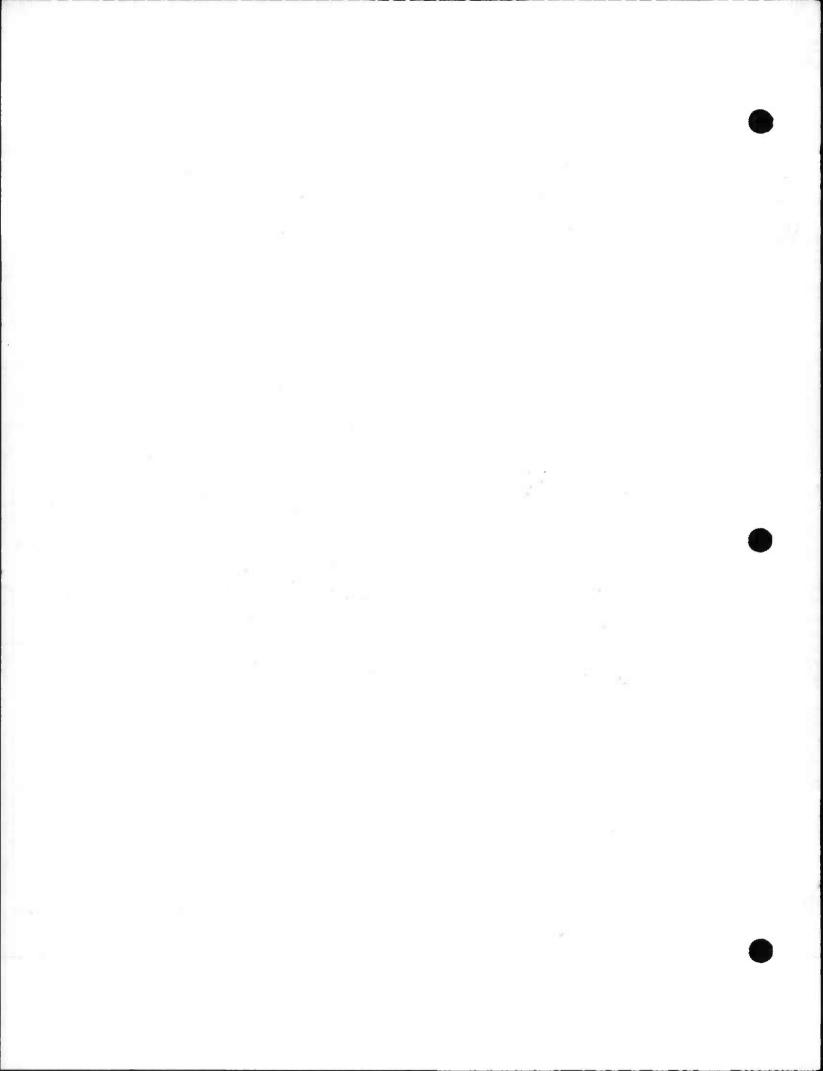
TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



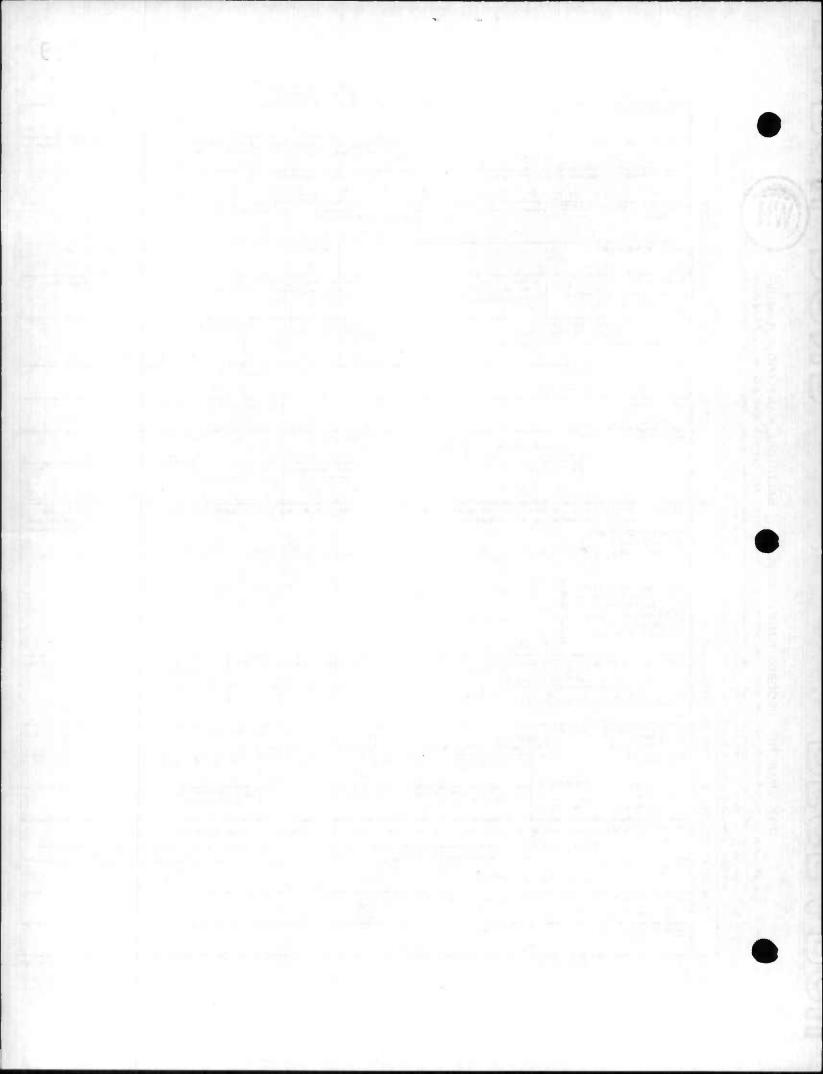
1. DECEDENT'S NAME (First,	Middle, Last)								OF DEATH			3. TIME OF DEATH
Joh	m l	F. Har	rison						Feb		19	95	11:00 A
4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs	s. lest birthday)		R 1 YEAR	IF UNDER			OF BIRTH		8. BIRT	THPLACE (State or Foreign
056-14-4624	1	1 ₹ M 2 □ F	93	YRS.	MONTHS	DAY8	HOURS	MIN.		21,	1901		v York
9e. FACILITY NAME (If not ins	stitution, give	street end number)			9b. CIT	Y, TOWN	OR LOCATI	ON OF DE				INTY OF	
Bon Secours	Exte	ended Car	ce Faci	lity	F	Illic	ott	City				Howa	ard
RESIDENCE OF DEC	EDENT							<u>OLC</u>			_	11000	ii d
10e. STATE	10b. COUN	TY		10c. CIT		OR LOCAT							10d. INSIDE CITY LIMITS?
Maryland	H	oward			Ell:		t Cit						1 TYES 2 NO
10e. STREET AND NUMBER						101	. ZIP COD	E			10g. CIT	IZEN OF	WHAT COUNTRY?
3000 N. Rid	ge Ro						2104						States
11. MARITAL STATUS 1 Never Married 2 🔀 3 Widowed 4 Divor		12. WAS DECED FORCES? UF YES, GIVE	ENT EVER IN U.S 1 YES 2. WAR OR DATES	NO NO	13.	If yes, sp		n, Mexica	n, Puarto	N? (Specify Ve Ricen, etc.)	ee or No-		CE — American Indian, ck, White, etc.
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8				Main	tena	nce			C	olgate	e Uni	vers	sity
17. FATHER'S NAME (First, Mi	iddle, Last)						18. MOT	HER'S NA		Middle, Maide			
Elmer H	larris	son					M	arv	Ann	McLaud	ahlin		
19e. INFORMANT'S NAME (7)				19b, MAILING	G ADDRES	SS (Street e				ber, City or To			
Sally Brown)			7338	Moss	SV B	rink	Cour	+ 0	olumbi	a MD	210	45
200. METHOD OF DISPOSITI	ON		20b. PL/	ACE AND DATE	OF DISPO	SITION (Na		- Cul	DAT		OCATION -		
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21. SIGNATURE OF FUNERAL		ICENSEE	1 Dail	L Wasi					/ 1 La	mer,	I'ld	Lyland	
A. OIGHAI OHE OF FUNERAL	C SELLAIGE I			22. NAME AND ADDRESS OF FACILITY Harry H Witzke Funeral									
	_	1 41 4	-0		H	larry	H W	itzk	e Fu				
► Xarre 23. PART I. Enter the di	seases, or	. List only bna/c	hat caused the euse on each	line.	H 4 not ente	larry 112 or the mo	Old of dy	itzke Colu Ing, auci	e Fumbia	Pike	Elli piratory ar	cott rest,	Approximate Interval Betw
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within flours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transfer be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. **BALTIMORE, MARYLAND 21215-0020**

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



131
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within at hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as in the befield within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-1021

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Pages 1, 2, 3 should

	1 - FOR STATE REGISTRAR	STATE OF MAR	YLAND / DEPARTI	MENT OF HEALTH		NTAL HYGIEN		
ĺ	1. DECEDENT'S NAME (First, Middle, Last)				2.	DATE OF DEATH		3. TIME OF DEATH
	FREDERICK	A. h	URLBUR"	T. SR.		BRKARY		995 3:40 AM
	4. SOCIAL SECURITY NUMBER		GE (In yrs. last birthday)	F UNDER 1 YEAR IF UNDER	24 HRS. 7.	DATE OF BIRTH	8.	BIRTHPLACE (State or Foreign
	219-16-1071	1 ☑ M 2 ☐ F	70 YRS. M	ONTHS DAYS HOURS	MIN. S	(Month, Day, Year) Sept 25 1	1	country) laryland
	Se. FACILITY NAME (If not institution, give st	reet and number)	9	b. CITY, TOWN OR LOCATIO			9c. COUNTY	
OR	Charlotte Hall V	eterans' H	ome	Charlotte	Hall		St.	Mary's
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY							
DIRECTOR		Mary's		own on Location arlotte Hal	1			10d, INSIDE CITY LIMITS?
	100. STREET AND NUMBER	Mary S	CII					1 TES 2 NO
FUNERAL				10f. ZIP CODI	7.			N OF WHAT COUNTRY?
N.	Rt. 2 Box 5	12. WAS DECEDENT EVI		2062			US	
	1 Never Married 2 Merried	FORCES? 1 XY	ES 2 NO	13. WAS DECENDENT O	n, Maxican, Pe		or No 14	. RACE - American Indian, Black, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR O		1 🗆 YES 2 🙀 NO	Specify:			Specify: White
8	15, DECEDENT'S EDUC	CATION	16e. DECEDENT'S US	UAL OCCUPATION		16b. KIND OF BUS	INESS/INDUS	
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of world life. Do NOT use n	done during most of worldnestred.)	g			
릴	.com/www.youndesc	2	Butcher			Retail F	ood Ir	ndustry
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					First, Middle, Malden		1
BE (Lloyd Hurlburt			Ra	chael	Warren		
2	19e. INFORMANT'S NAME (Type/Print)			DRESS (Street and Number				
-	Rebecca Cane		14 Circ	cle Avenue,	India	an Head,	Md 206	540
	20e. METHOD OF DISPOSITION 1	oval from State	20b. PLACE AND DATE OF I	placel		DATE 20c. LOC	CATION — City	or Town, State
	Donation 5 Other (Specify)		Trinity Mer	morial Gard			orf, N	D
	21. SIGNATURE OF FINERAL SERVICE TO	popolite	t	Huntt Fun	eral F	ry Home, Inc		
	Shirley Capor	aletti M	00844	P. O. Box				0604-0156
	23. PART I. Enter the diseases, or c shock, or heart feilure. I	omplications that cau	sed the deeth. Do not	anter the mode of dyl	ng, such aa	cardiac or respli	ratory arrest	
	IMMEDIATE CAUSE (Final							Onset and Death
	disease or condition resulting in death)	1-150	as a consequence of):	Preus	20110			
		DUE TO (OR	AS A CONSEQUENCE OF):		,		1	
2	Sequentially list conditions,	. Mult	ple Cere	600 Vaseu	lai	Acude	1-5"	
CERTIFICATION	If any, laeding to immediate cause. Enter UNDERLYING	OUE TO (OR A	AS A CONSEQUENCE OF):					
E C	CAUSE (Disease or Injury that initieted events	OUE TO (OR (AS A CONSEQUENCE OF):					
E	resulting in death) LAST							
S		J						
A P	PART II. Other significent conditions	contributing to deet	h but not resulting in t	he underlying ceuse g	iven in Part	1. 24a. WAS AN A		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
	140	E I Do	betes			1 TYES 2		COMPLETION OF CAUSE OF DEATH?
M								1 YES 2 NO
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEATH YES	□ NO □ UNC	ERTAIN [
등	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF OEATH (
YSI	1 VES 2 NO	1 Inpatient 2 ER/C		THER: Nursing Home 5 - Ra	sidence 8 🗆	Other (Specify)		
표	27. MANNER OF DEATH 1 Netural 5 Pending	28a. OATE OF INJUI	RY 28b. TIME O	F 28c, INJURY AT WORK?	280	1. OEȘCRIBE HOW IN	JURY OCCUR	ED
B	2 Accident Investigation			M 1 YES 2	NO			
	3 Suicide 6 Could not be 4 Homicide determined	building, atc. (S	URY — At home, ferm, stree Specify)	et, factory, office	281	. LOCATION (Street el City or Town, State)	nd Number or I	Rural Route Number,
COMPLETED	an agreement							
P P	(Check only		nowledge, death occurred a					
8	2 MEOICAL EXAMINER	I: On the basis of examin	ation and/or investigation, i	n my opinion, death occur	ed at the time,	, date end placa, end	due to the co	suse(e) end manner ee stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIED	1115	1		NSE NUMBER		29d. DATE SI	GNED (Month, Day, Year)
0		100	9)		7331	15	12	195
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF						
	JON, LOWEN		D. ARIA	VCE FRE	DORIGO	EK, MI	>	
	FFB 0 3 1995	32. REGISTRARIES	IGNATURE Pardall			,		
	LEDOO							

(VI	11	1, 2, 3 should)
ALTIMORE, MARYLAND 21215-0020	leath, Page 6 may be retained by the hospital or attending physician.	funeral director, page 5 should be detached for use as the burial-transit permit. Profit	examiner must be notified at once

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signed by the attending physician and completely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal.

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with DIVISION OF VITAL RECORDS, P.O. BOX 68760

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DIRECTOR: /

TO THE FUNERAL C be filed within 72 h

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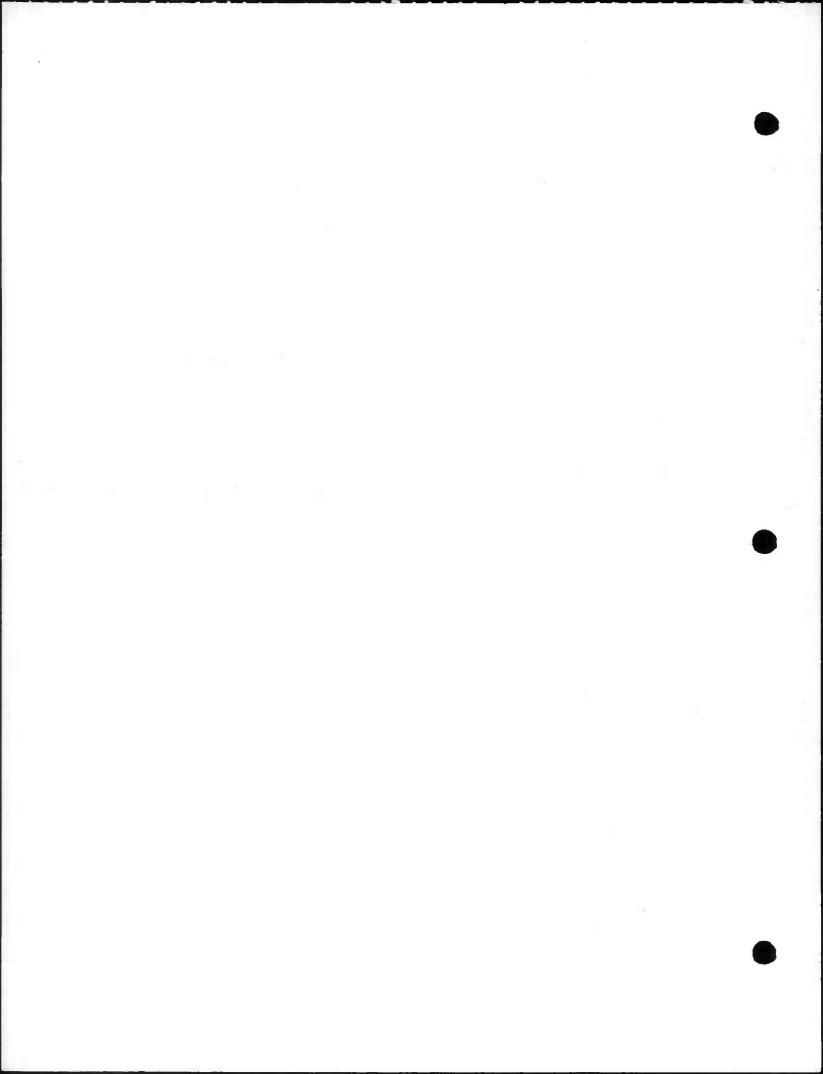
BALTIMORE, MARYLAND 21215-0020

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN February 3, 1995 9 P Fred Hepworth Hayward 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign MIN. November 27 1906 518 07 7328 DAYS HOURS Utan 1 X M 2 🗌 F YRS. 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH SOLOMONS Calvert 14839 Patuxent Avenue DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Calvert Solomons Maryland 1 YES 2 X NO 10a STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 14839 Patuxent Avenue 20688 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES ВҰ Specifiwhite 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16h. KIND OF BUSINESS/INDUSTRY Elamentary/Secondary (0-12) mechanic/body repair/salesman College (1-4 or 5 +) Attomble autombile 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Charles Edward Hayward Martha Annice Hepworth 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14839 Patuxent Ave. Solomons Maryland Lynda Adams 20a METHOD OF DISPOSITION
1 Burlal 2 Coremation 3 Removal from State 20b.PLACE AND DATE OF DISPOSITION (Na Tebruary DAE 1949 GCATION - City or Town, State 4 Donation 5 Other (Specify) Metropolitan Funeral ServiceAlexandria Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic Maryland 20676 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ahock, or haart failure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition Chionic months resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequantially list conditions, If any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF) CAUSE (Disease Dr Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 TYES 2 T NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO VINCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) HOSPITAL OTHER 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 -4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DEŞCRIBE NOW INJURY OCCURED 1 Natural 5 Pending BY 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Nomicide determined CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month Day Year) F81258 95 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, Year) Evolus Randall FEB 06

DHMN-16 Rev 1/89



FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFI	CATE OF	DEATH	R	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	OEATH		3. TIME	OF DEATH
	Lorraine		Hawkins			MONTH	DAY	YE	10000	x 000m
	4. SOCIAL SECURITY NUMBER 5. SEX		yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF E	, , , , , , , , , , , , , , , , , , ,	> 7		State or Foreign
	219-50-9657 1 □ M 2			MONTHS DAYS	HOURS MIN.	Nov.	y, Year)	0	Country)	
	9e. FACILITY NAME (If not institution, give street and num	ber)		9b. CITY, TOWN	OR LOCATION OF D			De. COUNTY		ıu
OR	1221 Sturdee Drive	,			larlboro				Georg	re t s
ט	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY									
DIRECTOR	Maryland Prince Geo	rge's		per Mai					LIN	SIDE CITY HTS? ES 2 K NO
	10e. STREET AND NUMBER			10	1. ZIP CODE		1	IOo. CITIZEN	OF WHAT COL	
FUNERAL	1221 Sturdee Drive				20772			US		
	1 Never Merried 2 Merried FORCE	CEDENT EVER IN U	2 X NO	If yes, sp	CENDENT OF HISPA Hecify Cuben, Maxic	en, Puerto Ricar		No- 14.	RACE — Amer Black, White,	icen Indian, elc.
ВҰ	3 Wildowed 4 Divorced	GIVE WAR OR DAT	ES	1 🗌 YES	S 2 NO Speci	ty:			Specify: B1	ack
딢	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	1	16e. DECEOENT'S U	ork done during me		16b. KIN	D OF BUSIN	ESS/INOUST	RY	
COMPLETED	Elementary/Secondary (0-12) College (1	4 or 5 +)	Securit			77 - 7	1			
M	17. FATHER'S NAME (First, Middle, Last)		securit	y Exami				Gover	nment	
		Hawkins			18. MOTHER'S N.	AME (First, Middl		_{mame)} Randa:	11	
BE	19e. INFORMANT'S NAME (Type/Print)		196. MAILING	ADDRESS (Street	and Number or Rural	Route Number, (
임	Tracy Gross			ox 473		gs, MD				
	20a, METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Removal from S	20b. P	LACE AND DATE OF	DISPOSITION (N	ame of	OATE	20c. LOCA	TION — City	or Town, State	
	4 Donation 5 Other (Specify)	Co	oper's U	M Churc	h Cem. 2	17/95	Du	nkirk.	, MD	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE			22. NAME A	ND AODRESS OF FA	Se Se	well	Funera	al Hom	е
	Spencer E. Se	well		1451 E	ares Bea	ich Rd.	Prin	ce Fre	ederic	k, MD
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A COULE TO (OR A	ONSEQUENCE OF)	:						
E I	d									
DICAL	Congestive he mutushtil li	nt fei	sease				YES 2	D?	COMPLE DF DEAT	TTOPSY FINDINGS LE PRIOR TO TION DF CAUSE H? S 2 \(\subseteq \text{NO} \)
ž	DID TOBACCO USE CONTRIBUTE TO	O CAUSE OF	DEATH YES	NO G	UNCERTAI	N 🗆				
PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		. PLACE OF DEATH	(Check only one)		i i				
Z		nt 2 🗆 ER/Outpat			ne 5 Aesidence	6 Other (Sp	ecify)			
	1 Natural 5 Pending	ATE OF INJURY fonth, Day, Year)	28b. TIME INJU	RY WO	DURY AT DRK? YES 2 \(\bar{\cup} \) NO	26d. DESCRI	BE HOW INJU	JRY OCCURE	D	
р ВУ	_ Codid not be	LACE OF INJURY -	At home, farm, atr				N (Street and wn, State)	Number or R	ural Route Num	iber,
	4 Homicide determined									
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the back only one) 2 MEDICAL EXAMINER: On the back of t								use(s) and mer	nner as stated.
ш∥	296. SIGNATURE AND TITLE OF CERTIFIER	N			29c. LICENSE NU	MBER	2	9d. DATE SIG	NED (Month, D	Day, Year)
0	Manufan S. C.	mho	an /		03	362	23	12,	16/9	5
F	30. NAME AND ADDRESS OF PERSON WHO COMPLETE				- 1 / 0	<i>C</i> :	0.		(
	31. OATE FILEO (MONTH, Day, Year) 32. RE		19 CH	CAPE	EAKE P.	CACIL	170	, OW	11065	(101)
	FEB 0 6 1995	Strak's SIGNAT	x-Rardall							

BALTIMORE, MARYLAND 21215-0020

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the law requires that the death of the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

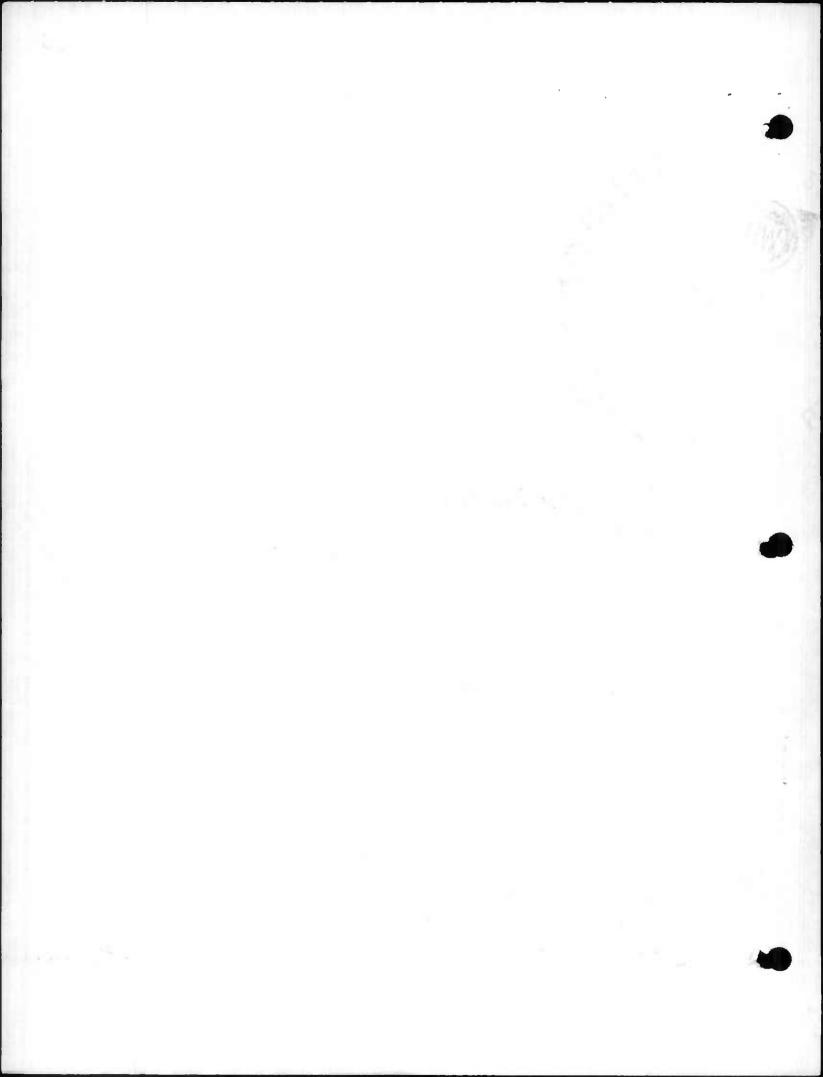
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wirthin which a site death. Page 6 may be retained by the hospit	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely wifed in by the funeral director, page 5 should be detached be fled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
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death.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely wifed in by the funeral be fled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
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•	1	FOR STATE REGISTRAR		STATE OF !	MARYL					IEALTH DEAT		MENT	AL HYGIENI REG. NO.	E		
	1	1. DECEDENT'S NAME (First,	, Middle, Last)									2. DAT	TE OF DEATH	Υ	YEAR	3. TIME OF DEATH
	L	Robert	: Arth	nur Hos	hall	L						Fel	b. 11,	199	95	7:50 PM
		4. SOCIAL SECURITY NUMBER 218-14-74		5. SEX 1 M 2 F	6. AGE	(In yrs. las	t birthday) YRS.	IF UNDER	DAYS	HOURS	MIN.	(Mo	TE OF BIRTH inth, Day, Year) L. 8, 19	21	Coun	riplace (State or Foreign stry) ryland
		9a. FACILITY NAME (# not in	stitution, give s	treet and number)				9b. CITY	r, TOWN	OR LOCATI	ON OF DE				NTY OF	DEATH
8		3019 Cott		oad				M:	$ill\epsilon$	ers				Ва	lti	more
\ <u>\</u> 5		RESIDENCE OF DEC	10b. COUNT	Y			10c. CI	Y. TOWN	OR LOCA	TION						10d, INSIDE CITY
DIRECTOR		Maryland	Balt	timore				Mil	lers	5						1 YES 2 X NO
, ,	r	10e. STREET AND NUMBER							10	1. ZIP COD	E			10g. CIT	IZEN OF	WHAT COUNTRY?
FUNERAL		3019 Cc	otter	Road						211	07			U.	S.A	
15		11. MARITAL STATUS		12. WAS DECEDE FORCES?	T EVER	N U.S. AR	IMED	13.					GIN? (Specify Yee to Rican, etc.)	or No-	14. RAG Blo	CE — American Indian, ick, White, atc.
8		1 Never Merried 2 3 Wildowed 4 Dive		IF YES, GIVE	WAR OR E				1 TYES	2 📉 NO	Specifi	y:				White
			CEDENT'S EDU			/G	ilve kind of	work done	during me	ON ost of work	ing		66. KIND OF BUS			
PLE		Elementary/Secondary (0-12)	College (1-4 or 5	+)			ric:					Indepe Electr			
COMPLETED	ľ	17. FATHER'S NAME (First, A										ME (Fire	t, Middle, Meiden	Surneme)		
M M	-	Louis Ho		L		1 40							h Almo	_	in Cordal	
TO B		Carol We	**			12	2927	Co	ttei	r Rd	1	Mil	1000	MD	211	07
	ŀ	20e METHOD OF DISPOSIT			20	b. PLACE	OF DISPO	SITION (N	leme of ce	metery, cre	matory or	Woh.	15,20c.LO	CATION -	City or	Town, Slate
must be		1 & Burlel 2 Crematile 4 Donation 5 Other		noval from State	_ 7	V1SE	bur	g Ce	emet	ery		19	95 W	nite	На	all, MD
examiner	i	21. SIGNATURE OF FUNERA	AL SERVICE	arlem	Los	ni				Har Secon			in Mor	tua	ry,	Inc. PA 17349
II, ING MGGICAL		23. PART Lenter the chance of	haart fallure.	List only one ce	a	each line	е.	not ente	or the m		ying, suc	ch as c		irelory ar		Approximate Interval Between Onset and Death
L event.			-	DOE II	O (OR AS	h congr	7.RC	EV/	0			V				years
y, or other traumatic CERTIFICATION	!	Sequentially list conditif any, leading to immediate. Enter UNDERLY	ediate	DUE TO	O (OR AS	A COME	QUENCE	OF):								0
TIFIC		CAUSE (Disease or in) that initiated events	lury	G. DUE T	BA RO) O	A CONSE	QUENCE	DF):								
ERT		resulting in death) LAS	ST	d												
ted, or item 23 shows any injury, PHYSICIAN: MEDICAL CI	- 11	PART II. Opho algnific	cant condition	na contributing t	lu	but not	resulting	in tha u	undariyi	ng cause	given ir	Part I	24a, WAS AN PERFOI 1 YES	RMED?	2	Ab. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME				. –												1 YES 2 NO
AN:		25. WAS CASE REFERREO	TO MEDICA!	T					26	PLACE OF	DEATH (Q	neck on	ly one)			
SIC!	ŀ	EXAMINER?	- MILOTORE	HOSPITAL:	□ ER/O=	tpatient	3 🗆 DOA	OTHE 4 N	ER:		/		Other (Specify)			
H G	1	27, MANNER OF DEATH		28a. OATE (1	28b. T	IME OF	28c. II	JURY AT		_	DESCRIBE HOW	INJURY O	CCURED	
marked, BY PF		1 Natural 5 2 Accident	Pending investigation		Day, roar,			М		YES 2	□ NO					
28 Is		a 🗆 a 1-14:	Could not be determined	28e. PLACE buildin	OF INJUI g, etc. (Sp	RY — At h lec/ly)	ome, farm	, street, fa	ectory, off	lice			LOCATION (Street City or Town, State		er or Run	al Route Number,
IMPORTANT: If item D BE COMPLE		(Check only		SICIAN: To the best												se(a) and manner as stated.
PORTA BE	Ш	29b. SIGNATURE AND TITE	LE OF CERTIF	(Q - /)	0	~/	10			29c. L	CENSE NI	JABER /	55	29d, D/	ATE SIGN	NEO Month, Day, (bar)
P P		30. NAME AND ADDRESS	OF PERSON W	THO COMPLETED CA	WSE OF I	DEATH (IT	PM 27) (5)	pe, Print)	169	121	4	on	de la	10	11	02/1 Fact
		31. DATE FILED (Month, De		32. REGIST	BAR'S SI	MATURE	., .			- 1	(-,-	1	U	,	11000
		FEB 16	1995	year at all	wher h	A STA	4									Va All





DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an animal requires that the law requires that the law requires that the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF N	ARYLAND /	DEPAR	TMENT	OF H	EALTH DEAT	AND I	MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last) HILDA 4. SOCIAL SECURITY NUMBER	#1	RSHF						MONT	2		95	3. TIME OF DEATH
	579-20-7564 9a. FACILITY NAME (# not institution, give	5. SEX 1 M 2 XF	6. AGE (In yrs, Ia:	YRS.	IF UNDER	DAYS	HOURS R LOCATIO	MIN.	AUĞÜ	of Birth		NEW	
CTOR	HOLY CROSS HO	,			90. CIT,		LVER					TY OF DE	
DIRECTOR		Y TGOMERY			y, town o LLVEF							- 1	10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	11469 COLUMBI					10f.	209						STATES
BY	11, MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2 X	MED NO	1	yes, spe	ENDENT OF CURRENT OF C	, Maxica	n, Puerlo	N? (Specify Yea Rican, atc.)	or No—	Black,	— American Indian, White, alc.
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 1 2	CATION completed) College (1-4 or 5 +	(G life	CEDENT'S ive kind of v Do NOT us	vork done o e retired.)	luring mos	N t of working	,		FEDERA			ENT
BE CO	17. FATNER'S NAME (First, Middle, Last) NATHAN HIRSHF	IELD					HA	NNA	H FE	Middle, Maiden NSTERB	LATT		
5	19e. INFORMANT'S NAME (Type/Print) WILLIAM MINTZ	· · · · · ·		2 PE	ACH F	IILL	NORT				EW JE	ERSEY	07446
	200 METNOD OF DISPOSITION 1 13 Burlel 2 Commetter 3 Rem 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI	-/-	RIVER	STDE	CEME	TERY	ľ		1/2		I, NE		
	· Harry	I. He	ie		DA 11	NZAN .70 I	ROCKY	GOL	DBER E PI	KE – R	OCKV1	LLE,	ELS, INC. MD. 20852
	23. PART f. Entar the disease, prahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that List only one cause a.	caused the da	MAL	ot anter	the mod	la of dyli	ng, such	h as car	diac or reapi	ratory arr	est,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	. 1 Se	OH AS A CONSEI	OVY DUENCE(O		ns d	free	w	1				TWK TWK TWK.
MEDICAL (PART ii. Other significant condition	ns contributing to	death but not r	eaulting i	n the un	derlying	cause g	lven in I	Part I.	24a. WAS AN PERFOR	MED!		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
N. ME	DID TOBACCO USE CONT	RIBUTE TO CAL					UNC	RTAIN	- I	/		1	1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	/-	ER/Outpatient 3	DOA	OTHER	:	5 🗆 Ras	ildenca	8 🗆 Othe	r (Specify)			
ВУ РН	27. MANNER OF DEATN 1 Natural 5 Pending Accident Investigation	(Month, Da	y, Year)		M		RY AT IK? ES 2	ND	28d, DE	SCRIBE HOW IN	JURY OCC	URED	
ETED.	3 Suicide 8 Could not be 4 Homicide determined	building, a	INJURY — At he tc. (Specify)				-		City	ATION (Street a or Town, State)			ute Number,
COMPLETED	one) 1 MEDICAL EXAMINE	-											and manner as stated.
TO BE	30. NAME AND ADDRESS OF PERSON WIN	My	OF OF ATTH STEE				D-	32	37)	2	29d. DATE	SIGNED (Month, Day, Year)
	SK GWPTA 31. DATE FILED (Month, Dey, Year)	32. REGISTRAF	301 (rant)	A	vej	×2	20	Silv	er S	pruf	20902
	JAN 30 1995	Juli Same	hoo Rad	Ц									DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND /	DEPAR	TMEN1	OF H	EALTH AND	MEN.	TAL HYGIEI			
	1. DECEDENT'S NAME (First, Middle, Last)							2. D/	ATE OF DEATH			3. TIME OF DEATN
	Louis Albin Haley								n. 31,	1995	YEAR	7:40 A. M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. lest	birthday)	IF UNDER		IF UNDER 24 HRS.	7. DA	TE OF BIRTH		O. BIRTH	NPLACE (State or Foreign
	223-18-5765	1 🔀 M 2 🗆 F	75	YRS.	MONTHS	DAYS	HOURS MIN.		ne 16,	1919	Vire	
	9a. FACILITY NAME (If not institution, give stre	et and number)			9b. CITY	TOWN C	R LOCATION OF E			_	NTY OF D	
OR	Shady Grove Advent	ist Hospita	1		Rocl	kvil	le			Mon	tgom	erv
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY									1		
<u>E</u>			- 1		, TOWN C							10d. INSIDE CITY LIMITS?
	Maryland Montgo	mery		Gait	her							1 X YES 2 NO
FUNERAL		0.1				1 20	ZIP CODE					WHAT COUNTRY?
NE	407 Russell Ave. #	G-1 12. WAS DECEDENT EVER I				_	20877					States
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	D		f yea, sp	ENDENT OF HISPA	ANIC ORI	GIN? (Specify Ye to Rican, etc.)	a or No-	14. RACI Black	E — American Indian, k, White, alc.
ВУ	3 Widowed 4 Divorced	World War I			1 1	YES	2 XNO Spec	tty:			Speci	White
8	15. DECEDENT'S EDUCA	TION	18a, DEC	EDENT'S	USUAL O	CCUPATIO	ON .		16b, KIND OF BI	JSINESS/INC	DUSTRY	WILLE
H	(Specify only highest grade or Elamentary/Secondary (0-12)	College (1-4 or 5+)	(Give	e kind of w Do NOT use	ork done (e retired.)	during mo	st of working					
P		4	Prin	nting	g Off	fice	r	- 1	U.S. Ge	eolog	ical	Survey
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTNER'S N					
BE	William Ashton Hal	.ey					Eliza (Gree	n			
TO B	19a. INFORMANT'S NAME (Type/Print)		19b.	MAILING	ADDRESS	(Street a	nd Number or Rural	Route N	umber, City or To	wn, State, Zip	Code)	
F	Elizabeth F. Haley		40	07 Ru	ısse:	11 A	ve. #G-1	l, G	aithers	sburg	, MD	20877
	20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 X Remov		b. PLACE AN			ITION (Ne	me of	D	ATE 20c. L	OCATION -	City or To	wn, Slate
	4 🖺 Donation 5 🗆 Other (Specify)	Pi	rospe	ct H	<u>i11</u>	Ceme	tery	2,	/3 Fro	nt Ro	yal,	Virginia
	21. SIGNATURE OF FUNERAL SERVICE LICE	ASEE					Funeral					
) . S.x	XX.	_		-					ithor	chuz	g, MD 20877
1	23. PART i. Entar the diseases, or co	mplications that cause	d tha dea	th. Do no	ot anter	tha mo	da of dying, au	ch as c	ardisc or reep	piratory an	rest,	Approximate
	shock or heart failure. Li	et only ona ceuse on a	ach line.									Interval Between Onset and Death
	disesse or condition resulting in death)	Konnis	ah		F	716	lune					1600
	resorting in death)	DUE TO FOR AS	A CONSEQU	JENCE OF	1 0		we					I III
Z	Summerable the translation of b.	Preun	cos	2	_							1 DAU
5	Sequantielly list conditions, if any, leading to immediate	DUE TO (OR AS A	A CONSEOL	JENCE OF		,						121
3	CAUSE (Disesse or injury	Kight U	ope.	2	10D	e	obecto	MY				13 days
	that initiated events resulting in death) LAST	Right of DUE TO (OR A)	A GONSEOL	JENCE OF):		C 80	/.	,			1 00 +1
CERTIFICATION	d.	HACNOCA	766/1	VON	14	0 1	- KIGI	421	LUNG	7		MUMIN
AL	PART ii. Other eignificent conditions	contributing to death b	out not ras	sulting in	tha un	derlying	cause givan in	Part i.	24a. WAS A		24b.	WERE AUTOPSY FINDINGS
20	GROWARY AR	tery Di	seA.	se.					PERFO	1,100		AVAILABLE PRIOR TO COMPLETION OF CAUSE
WE												OF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEAT	H YES	1 🗆 2	10 🗆	UNCERTAI	N X				
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE									
YSI	1 VES 2 NO	X Inpatient 2 ER/Outp	patient 3		OTHER		5 Residence	6 🗆 0	ther (Specify)			
F	27, MANNER OF DEATN 1 X Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)		26b. TIME		26c. INJU		26d. [ESCRIBE NOW	INJURY OC	CURED	
B⊀	1 Natural 5 Pending 2 Accident Investigation				M		ES 2 NO					
	3 Suicide 6 Could not be 4 Nomicide determined	28e. PLACE OF INJURY building, etc. (Spec	(— Al hom city)	e, farm, st	reet, facto	ory, office		28f. L	OCATION (Street ity or Town, State	and Number	or Rural R	loute Number,
COMPLETED												
AP L	29a. CERTIFIER (Check only one)	AN: To the best of my know	rledga, daat	h occurred	at the ti	me, data	and place, and du	a to the	cause(a) and ma	nner as stat	ed.	
Ö	2 MEDICAL EXAMINER:	On the basis of axaminatio	n and/or Im	veatigation	, in my o	pinion, de	eath occured at the	e time, d	eta and placa, a	nd dua to th	e cause(s) end manner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	-// -					29c. LICENSE NU	MBER		29d. DAT	E SIGNED	(Month, Day, Year)
10 E	Degen H	esker m)	-			Da64	43		TA	VUAR	y 31, 1995
-1	METHORE AND ASIDHESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM	27) (Type: 1	Print)	-						(Month, Day, Year) y 31, 1995 14) 20750
	GREGORY HIT	ITHOR 1	1522	35	Sha	dy	GROVE	2 /	ed R	ock	ilk	141)20850
	FEB 02 1995	32 REGISTRAR'S GIGN	n-hand	all		•					7	
	LED 07 1222	Mm										

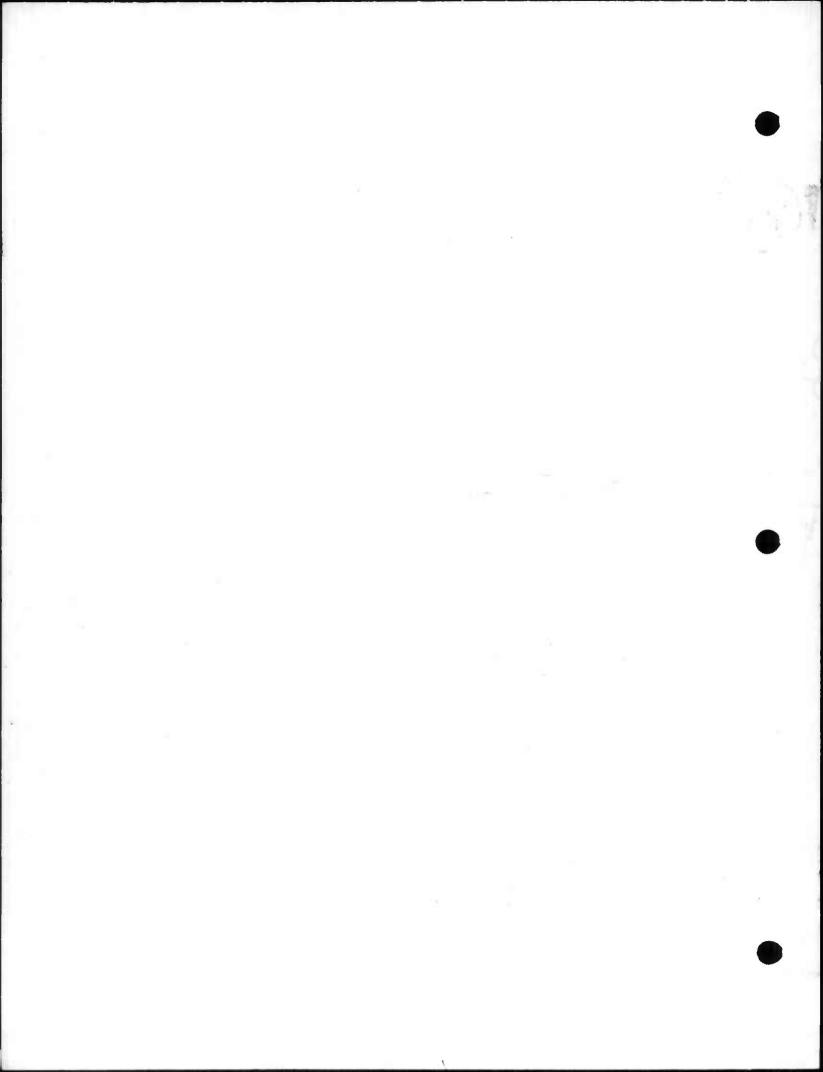
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be intained by the intending physician and completely filled in by the function, page 5 should be detached for use as the burish-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be nutified at once.

DHMH-18 Rev 1/89



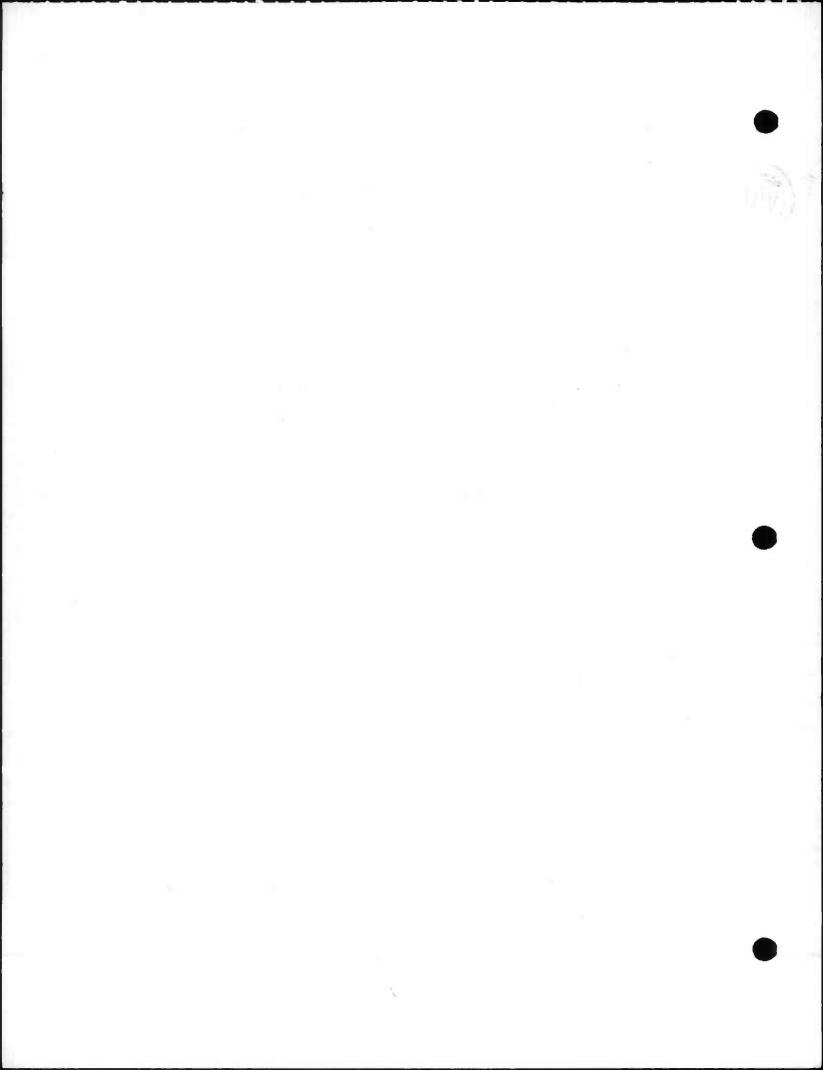
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Jours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit to be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR

	1 - STATE REGISTRAR	SIAIL OF I	CI		ICATE				MEN IA	REG.				
	1. DECEDENT'S NAME (First, Middle, Last)								MON	E OF DEAT	DAY	,	YEAR	3. TIME OF DEATH
	IRENE		IMELFAR						FEBR	ÜARY	1,	1995	5	2:00 PM M
	4. SOCIAL SECURITY NUMBER 579-54-5298	5. SEX	6. AGE (In yrs. las		MONTHS		HOURS	24 HRS. MIN.	(Mor	E OF BIRTH	17)		Countr	
	9e. FACILITY NAME (If not institution, give st	21	82	YRS.	21.0		11		MAR	CH 1	, 19			RYLAND
Œ	263 CONGRESSION	,	#412			CKVI		ON OF DI	EATH				NTY OF DI	
CTC	RESIDENCE OF DECEDENT		" 122		KO	ORVI.						MON	1 LGOM	IEKI
DIRECTOR	MARYLAND MON	TGOMERY			Y, TOWN O		ON							10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	TGOMERY		1	ROCKV				_					1 YES 2 NO
RA	263 CONGRESSION	IAT. LANE	#412			10f. 7	208					_		/HAT COUNTRY?
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AF	MED	13, W	WAS DECE			NIC ORIG	IN? (Specify	Van i	_		STATES - American Indian,
BY F	1 Never Merried 2 Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W	YES 2 1	40	11		Ity_Cubar		in, Puarto	Rican, etc.			Black Specifi	, White, atc.
	15. DECEDENT'S EDUC	CATION	16e, DE	CEDENT'S	USUAL OC	CUPATION			16	b. KIND OF	BUSI	NESS/INC	HISTOV	WIIIIE
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5 +	(G	ive kind of Do NOT u	work done di	uring most	of workin	g	100	u. KIND OF	6031	ME33/INL	7051RT	
MP.	12			ALES	CLERI	K				RE	ETA	IL		
00	17. FATHER'S NAME (First, Middle, Last)	-								Middle, Ma		,		
B	CHARLES FRIED									IE BE				
2	19a. INFORMANT'S NAME (Type/Print) RONNYE LEVIN	(DAUGHT			ADDRESS VINEGI									0055
	20a. METHOD OF DISPOSITION		20b. PLACE					K1-1	JEKW		-		City or Ton	
	1 X Buriel 2 Cremation 3 Remo	oval from State	B NAT	meter SR	AEL C	ONG.	CEI	1.	2/3					MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	,		22 N	IAME AND	ADDRES	C OF FA	CILITY		_			ELS, INC.
	Kolent	X/			111	70 R	OCKV	TT.T.F	אםפע דים דים	G MEM	OK	VIII	F MA	RYLAND 20852
	23. PART i. Enter the diseases, pr c shock, pr heart failure. I	omplications that	caused tha de	ath. Do	not antar t	the mode	of dyle	ng, suc	h as csi	disc or re	apln	atory sri	est,	Approximata
	IMMEDIATE CAUSE (Final	List Drily Ona Cau	se on asch ling					1						Interval Between Onset and Daath
	disesse or condition reaulting in dasth)		ance	no	mi		41	1	12	ar	2			1-200
	_	DUE TO	(OR AS A CONSE	DUENCE O	F):		1	0	0 20 1		(, ,,,,
CERTIFICATION	Sequantially list conditions, if any, leading to immediate	DUE TO	OR AS A CONSE	DUENCE O	F):	-6	/-							
CAI	cause. Entar UNDERLYING CAUSE (Disease or Injury	à												
E	that initiated avents resulting in death) LAST	DUE TO	OR AS A CONSE	DUENCE O	F):									i.
HS		1						_						
	PART II. Other significant conditions	contributing to	daath but not r	eaulting	In tha und	derlying	cause g	lven in	Part i.	24a, WAS	AN A		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
DICAL			_							1 TYE				COMPLETION OF CAUSE OF DEATH?
ME														1 YES 2 NO
AN	DID TOBACCO USE CONTR	RIBUTE TO CAI					UNC	ERTAIL	N 🗆					
I I	EXAMINER?	HOSPITAL:			OTHER									
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIM		28c. INJUF	TA YE	ildenca		er (Specify) SCRIBE HO	W IN.	JURY OC	CURED	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Da	ly, Year)	LNI	URY M	1 YE	(7 S 2 🗌	NO						
	3 Suicide 6 Could not be	28s. PLACE DE building,	F INJURY — At ho	me, ferm, i	street, facto	ry, offica			28t. LO	CATION (Str.	eel an	d Number	or Rural A	oute Number,
	4 Homicide determined										,			
COMPLETED	29a. CERTIFIER (Check only one)													
00	2 MEDICAL EXAMINES	R: On the basis of ax	amination end/or i	nveatigatio	n, In my op	Inlon, dea	th occure	d at the	time, det	e and place	, and	dua to th	e cause(a)	end manner as stated.
BE	295. SIGNATURE AND TITLE OF CERTIFIER	6001)			2	9c. LICE	NSE NUN	ABER .		-	29d. DATI	SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E OF DEATH (ITE	4 27) /Time	Orint)		01	02	05		\perp	TAK	nul	ry 1 1498
	STANLEY SILVERB					NUE -	- CH	EVY	CHAS	SE, M	AR'	YLAN	D 20	815
	31. DATE FILED (Month, Day, Year)		AND STANDER											





1	-	STATE REGISTRAF
ш.		

1 - STATE REGISTRAR		SIAIE UF MA			ICATE (או טו		REG. NO.	_			
1. DECEOENT'S NAME (First	t, Middle, Lest)							T	2. DATE OF				3. TIME OF DEA	NTH .
JOHN E. HILEMAN									JAN.	27		995	6:00	Ам
4. SOCIAL SECURITY NUMBER			AGE (In yrs. les	st birthday)	IF UNDER 1 YE	_	F UNDER 24 HF	_	7. DATE OF (Month, De	mr Wanel		8. BIRTH Count	IPLACE (State or I	Foreign
175-32-515		1 X M 2 - F	54	YRS.	MONTHS DO	ATS H	IOUNS MI	N.	Mar 2	23,	1940	Per	nsylvar	ia
9e. FACILITY NAME (If not is					9b. CITY, TO	WN OR	LOCATION O	F DEA	ATH		9c. COU	NTY OF D	EATH	
Magnolia Garde	Magnolia Cardens Nursing & Rehabilitation Ctr. Lanham										Pri	nce	George':	S
10a. STATE													10d. INSIDE CIT	v
Maryland	Prince	George's	S	Lan	ham								LIMITS?	
10e. STREET AND NUMBER				1	T Call	101. Z	IP CODE				10g. CIT	IZEN OF	WHAT COUNTRY?	, 40
6862 Rivero	lale Roa	ıd				20	706				Uni	ited	States	
11. MARITAL STATUS		2. WAS DECEDENT E			13. WAS	DECEN	DENT OF HIS	SPANI	C ORIOIN? (S	pecify Yes			E — American Ind	len,
1 Never Married 2 3 3 Wildowed 4 Dive		IF YES, DIVE WAR		10			X NO S		, Puerto Rica	n, etc.)		Spec	ffy:	
	EDENT'S EDUCA	TION	1 40- 04	OFFICE	USUAL OCCU								White	
(Specify onl	y highest grade co	mpleted)	(G	ive kind of w	vork done durin	most o	of working		16b. KII	ID OF BUS	SINESS/IN	DUSTRY		
Elementary/Secondary (t	F-12)	College (1-4 or 8+)	Ma	anage	Г				R	etai i	Sto	re		
17. FATHER'S NAME (First, M	liddle, Lest)			3		1	8. MOTHER'S	S NAM	E (First, Midd					
Edwin		Hileman					Jean					onne	211	
190. INFORMANT'S NAME (Type/Print)		19	b. MAILINO	ADDRESS (St	neet and	Number or Re	lunal Ro	oute Number, (Olty or Tow	n, State, Zij	p Code)		
Mary Anne H		(Wife)		Same	as #1	10								
20e. METHOD OF DISPOSIT	n 3 🗆 Remove	al from State			F DISPOSITIO		of		OATE			City or To		
4 Donation \$ Donat		ioer /	Mt.	Airy	Cemete				1-30	Nat	rona	Hei	ghts, F	Α
an diditarone on ronena	11 D	11/					ADDRESS OF		ervic	es.	P.A.			
1.20	4-13.	M			933	Gi	st Av	e.	Silve	r Śp	rina	, MD	20910	
23 PART I. Enter the d shock, or h	iseases, or cor eart fellure. Lis	mpilcet(ons thet c it only one cause	aused the da	ath. Do n	ot enter tha	moda	of dying,	such	as cardiec	or reapi	ratory an	reat,	Approxin	
iMMEDIATE CAUSE (Fir		((1		1		1 1				Onset an	
recuiting in death)	→ a.,	MCINE	Mu OY	Par	D May 1	W	(1)	Me	Tast 1	1			OVE	mus /
		DUE TO (OI	R AS A CONSE	DUENCE OF	n): '									
Sequentielly list condit		DUE TO (OF	AS A CONSEC	DUENCE OF	n:									
If any, leading to imme ceuse. Enter UNDERLY	ING												ĺ	
CAUSE (Disease or injute that initiated events	· .	OUE TO (OF	AS A CONSEC	DUENCE OF):									
reaulting in deeth) LAS	T d.													
PART II. Other aignifice	nt conditions	contributing to de	eth but not r	eaulting i	n the under	lylna c	ause alven	in P	art i 24	. WAS AN	AUTOREV	245	WERE AUTOPSY F	minuos.
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							/		- [10	YES 2	NO NO		OF DEATH?	
DID TOBACCO U	SE CONTRI	BUTE TO CAUS	SE OF DEA	TH YE	S II NO	ТИ	UNCERT	ΔΙΝ				Ì	1 TES 2 X	NO
25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL				H (Check only		OTTOEKT.							
1 YES 2 X NO		OSPITAL:	VOutpatient 3	□ DOA	OTHER:	Home !	5 - Residen	nce 8	☐ Other (Sp	ecity)				
27. MANNER OF DEATH		28e. DATE OF IN. (Month, Day,		28b. TIME	OF 28c	WORK	Y AT		28d. DESCRI		JURY OC	CURED		$\overline{}$
	Pending Investigation	,					2 🗌 NO							- 1
	Could not be	28e. PLACE OF It building, etc.	IJURY — At ho (Specify)	me, ferm, s	treet, factory,	office		1	281. LOCATIO	N (Street a	nd Number	or Rural F	loute Number,	
	datermined													
		N: To the beat of my												
2 MEOI	CAL EXAMINER:	On the basis of exam	ination end/or i	nveatigation	n, in my opinio	on, death	h occured at	the th	me, date and	place, and	due to th	ne ceuse(e) end manner ee :	stated.
29b. SIGNATURE AND TITLE	OF CERTIFIER	1.0				29	c. LICENSE	NUMB	ER		29d. DAT	E SIQNED	(Month, Day, Year)	
1740011/H	1////	W/W NA					10	27	2		J	anua	ry 27,	1995
30. NAME AND ADDRESS OF						D.	vatta	v:1	10 14	n 2	070/			
Frederick W. 31. DATE FILEO (Month, Day,		32. REGISTRAR'S	808 An	ιιαμυ.	TTO LO	, □	yalls	A T T	11c, M	U Z	0784	_		\blacksquare
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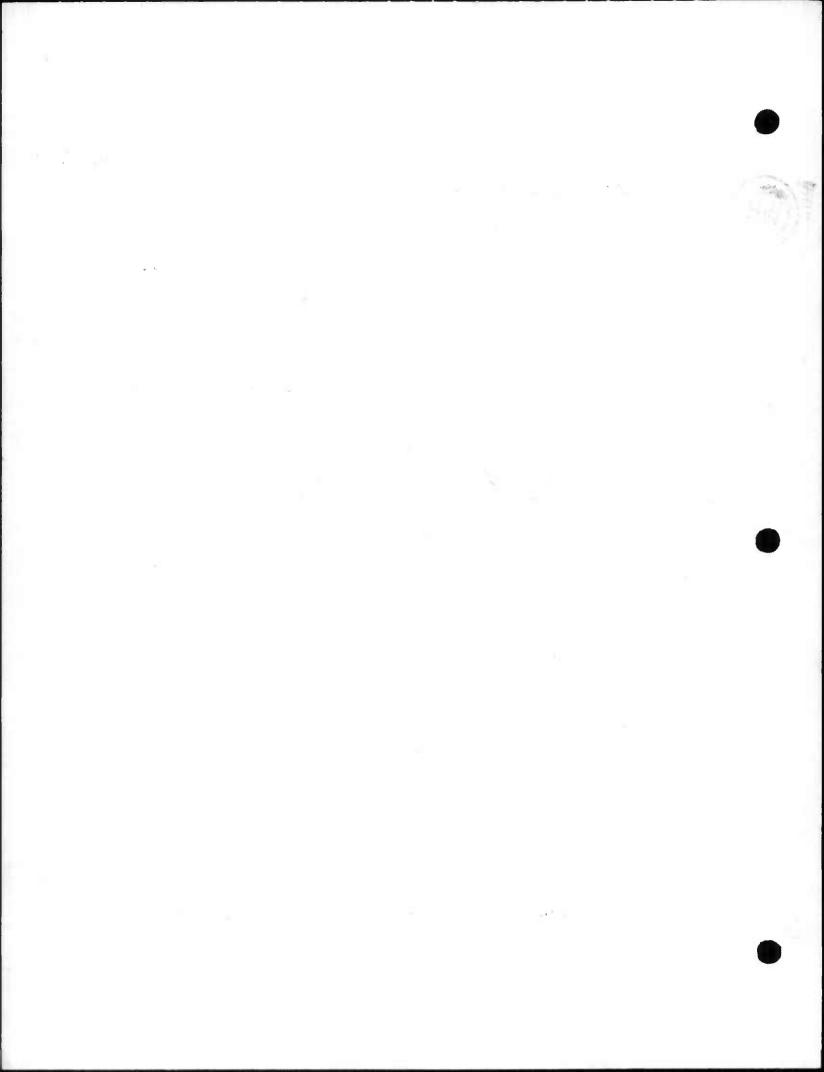


TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 27 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

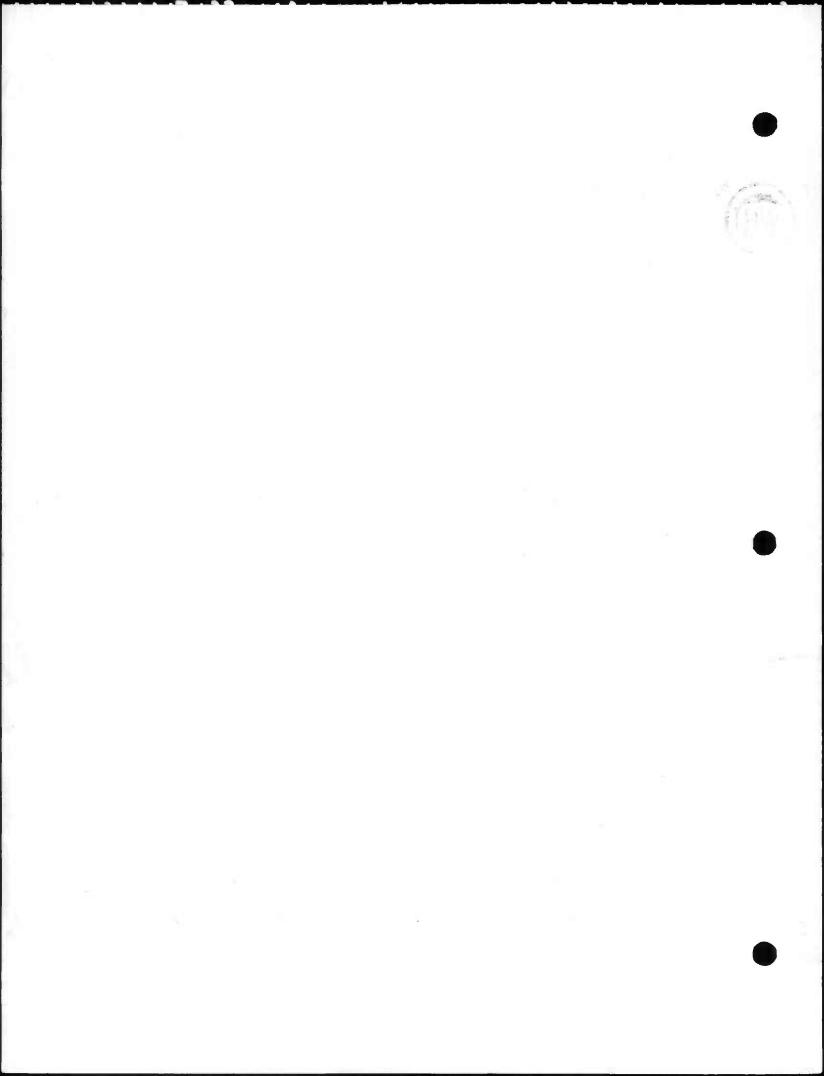
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	id in by the funeral director, page 5 should be detached for use as the burial-transit or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within more found after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND ME	ENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.														
	1. DECEDENT'S NAME (First, Middle, Last) HILDA	HERMAN			2. DATE OF DEATH	12 018	3. TIME OF DEATH							
	4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR IF UNDER 24 HRS. NTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Morith, Day, Year) January 3.		BIRTHPLACE (State or Foreign Country)							
OR	HOLY CROSS HOS	Y NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH MENTGO												
DIRECTOR	RESIDENCE OF DECEDENT 10c. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION													
	Maryland Montg	Maryland Montgomery Silver Spring												
FUNERAL	3330 N. Liesure Wo	rld Blvd. #	704	20906			d States							
ВУ	11. MARITAL STATUS 1	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2. NO	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic 1 YES 2 NO Speci	an, Puarto Rican, etc.)		RACE — American Indian, Black, Whita, alc. Specify: White							
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12)	TION ompleted) College (1-4 or 5+)	16a. DECEDENT'S USU (Give kind of work life. Do NOT use re-	done during most of working	16b. KIND OF BU	SINESS/INDUST	FRY							
MPL		5+	Reading S		Educati									
E CC	17. FATHER'S NAME (First, Middle, Last) Nathan Durlester				AME (First, Middle, Maiden Lessuck	Sumame)								
TO BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILINO AD	DRESS (Street and Number or Rural		n, State, Zip Coo	de)							
-	Jack R. Herman	l and					ring, MD.20906							
	20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 X Removal from Stale 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, or other place) King David Memorial Garden 1/29 Falls Church, VA.													
	22. NAME AND ADDRESS OF FACILITY Danzansky-Goldberg Memorial Chapels													
	Manh	a. 11	n	1170 Rockvill	e Pike Ro	ckvill	e, MD. 20852							
	23. PART I. Enter the diseases, or conshock, or heart failure. Lie	et only one ceuse on ee	ch line.			iratory arrest	Approximete Interval Between Onset and Death							
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) NECKOTIZING INFECTION (L) THIGH STUMP DUE TO (OR AS A CONSEQUENCE OF): ATTURO SCLAROTIC VASCUAR DISEASE													
z	DUE TO (OR AS A CONSEQUENCE OF): ATTHURO S CLAROTIC VASCUAR DISARS													
ATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING													
CERTIFICATION	CAUSE (Disease or injury that initieted events	DUE TO (OR AS A	CONSEQUENCE OF):											
E	resulting in deeth) LAST													
A	PART II. Other aignificent conditions	contributing to deeth bu	it not resulting in the	ne underlying cause given in	Part I. 24a. WAS AN PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE							
PHYSICIAN: MEDIC							DF DEATH? 1 YES 2 NO							
AN	DID TOBACCO USE CONTRIL 25. WAS CASE REFERRED TO MEDICAL		B. PLACE OF DEATH (C		Ν□									
SICI	EXAMINER?	IOSPITAL:	01	HER: Nursing Home 5 Residence	8 Other (Specify)									
РНУ	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT WORK?	28d. DESCRIBE HOW	NJURY OCCUR	ED							
ВУ	2 Accident Investigation	28s. PLACE OF INJURY	— At home, larm, stree	M 1 YES 2 NO	28f. LOCATION (Street	and Number or F	Rumi Route Number							
TEC	4 Homicida 8 Could not be	building, atc. (Speci	(y)		City or Town, State,									
COMPLETED				the time, data and place, and due my opinion, death occured at the			use(s) and manner as stated.							
	296. SECHATURE AND TITLE OF CERTIFIER			29c. LICENSE NU			GNED (Month, Dep. West)							
TO BE	Market Zy my).		D 24	886	▶ t/?	29/95							
	MARK H. EIG ,4	COMPLETED CAUSE OF DEA	6 Grongia	"Ave. Sieven	Spawis	Mp	20902							
	JAN 30 1995	32 REGISTRAR'S SIGNA	Rardall											



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NDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	s. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	
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ı		Amended # 1, FOR 1 - STATE REGISTRAR	# 12 STATE OF MARYLA	2/2/9 ND / DEPAR CERTIF	STMENT CATE	M F OF H	EALTH AND I	M _O	L HYGIEN REG. NO.	95 60m	ero	46.99			
	ì	DECEDENT'S NAME (First, Middle, Last)	illian G.	of Hon				MONT	OF DEATH	, 199 [§]	EAR 3.	TIME OF DEATH			
		4. SOCIAL SECURITY NUMBER		yrs. lest birthday)	ring		IF UNDER 24 HRS.	7. DATE	OF BIRTH	8.	BIRTHPLA	L1:45 A M			
18.00		053-24-2551	1 □ M 2 Ø F 84	YRS.	MONTHS	DAYS	HOURS MIN.	Marc	1 29, 10ar)	New	York				
HE)	œ	Sa. FACILITY NAME (If not institution, give str Collington Episcopal L		i+.,	I		R LOCATION OF DI	EATH		9c. COUNTY					
	67	RESIDENCE OF DECEDENT	Tre care compri		HIT	CITE	TIATITE			Princ	e Ge	orge's			
- Sec	DIRECTOR	Maryland Princ	e George's		r, rown o							I. INSIDE CITY LIMITS?			
permit.		100. STREET AND NUMBER	e deorge s	1411	CHET		ZIP CODE			10g. CITIZEN		YES 2 NO			
' ₩	FUNERAL	10450 Lottsford R					20721			Unite	ed St	tates			
hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit or removal. medical examiner must be notified at once.	BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 V YES IF YES, GIVE WAR OR DAT	U.S. ARMED 2 NO	11	f yes, spe	ENDENT OF HISPAT colfy Cuban, Mexice 2 X NO Specifi	n, Puarto I		or No— 14.		American Indian, hite, atc.			
attend Jse as	9	15. DECEDENT'S EDUC (Specify only highest grade of		18a. DECEDENT'S (Give kind of				16b	. KIND DF BUS			3			
the hospital or atte detached for use once.	PLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Economi	se retired.)	1000			ept. o	of Tra	aelim,	,			
detach once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		LOOMONIA	200		18. MOTHER'S NA				3301)	<u></u>			
d by t	BE	Louis Gottlieb			_		Fannie		nda		_				
5 should notified	5	Sidney Gottlieb					Number or Rural								
nay be page: page		20a. METHOD OF DISPOSITION 1 Burdel 2 Cremation 3 Removal from State Camplery Crematory of other place													
director, p		4 Donation 5 Other (Specify) Chesapeake Crematory 2-2 Beltsville, Maryland 21. SIGNATURE OF UNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
ter death. Pag the funeral dis oval.		21. SIGNATURE OF TUNERAL SERVICE LICE	Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20												
ation the		IMMEDIATE CAUSE (Final	lat Drily Dria causa Dri aa	ch ilna.	B \	tha mod	da of dying, auc	h aa carc	flac or reapl	,	Approximata interval Between Onset and Death				
and con burial,	RTIFICATION	DUE TO (DR AS A CONSEQUENCE DF): Sequentially list conditions, ff any, leading to immediate DUE TO (DR AS A CONSEQUENCE DF):													
ficate be e physician ne prior to	S	cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OD 40 4	2011250151125											
death certificat attending phys ental Hygiene p	CERTIF	that initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE O	*):										
nat the death by the atte and Mental ny Injury,	CAL	PART II. Other algorificant conditions	contributing to death bu	t not reaulting	In the un	derlying	cauaa given in	Part I.	24a. WAS AN PERFOR			RE AUTOPSY FINDINGS MLABLE PRIOR TO			
uires that signed b Health ar								-	1 TYES 2	_ to		MPLETION OF CAUSE DEATH?			
w requires been sign or, of Hea 3 shows	2										1 [YES 2 ND			
N: The law ficate has b State Dept.	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		ОТНЕЯ		ACE OF DEATH (Ch	eck only on	ne)						
SICIAN: The certificate the State	PHYSI	1 YES 2 NO 27. MANNER OF DEATH	1 ☐ Inpetient 2 ☐ ER/Outpet	tlent 3 DOA	4 Nurs		5 Rasidenca			1 H IPV 000 IP	50				
NG PHYS frer this cath with marked	BY PI	1 Natural 5 Pending	(Month, Day, Year)		JURY M	WOR	RK?	200. DES	CRIBE HOW IF	IJUNY OCCUR	EU				
DR ATTENDING POINTENDING POINTENDING PROPERTY POURS After death term 28 is man	ED I	2 Accident 3 Suicide 8 Could not be determined	28a. PLACE OF INJURY - building, etc. (Specif	At home, term,	atreet, facto	ory, office			ATIDN (Street a or Town, State)	nd Number or I	Rural Route	Number,			
로 로 전 =	COMPLE		EAN: To the best of my knowle								ause(a) and	d manner as stated.			
TO THE HOSPI TO THE FUNES Be filed within	TO BE C	296. SIGNATURE AND TITLE DE CERTIFIER					29c. LICENSE NUN			29d. DATE SI	GNED (Mo	onth, Day, Year)			
	- H	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	TH (ITEM 27) /Type	Print)						-				

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

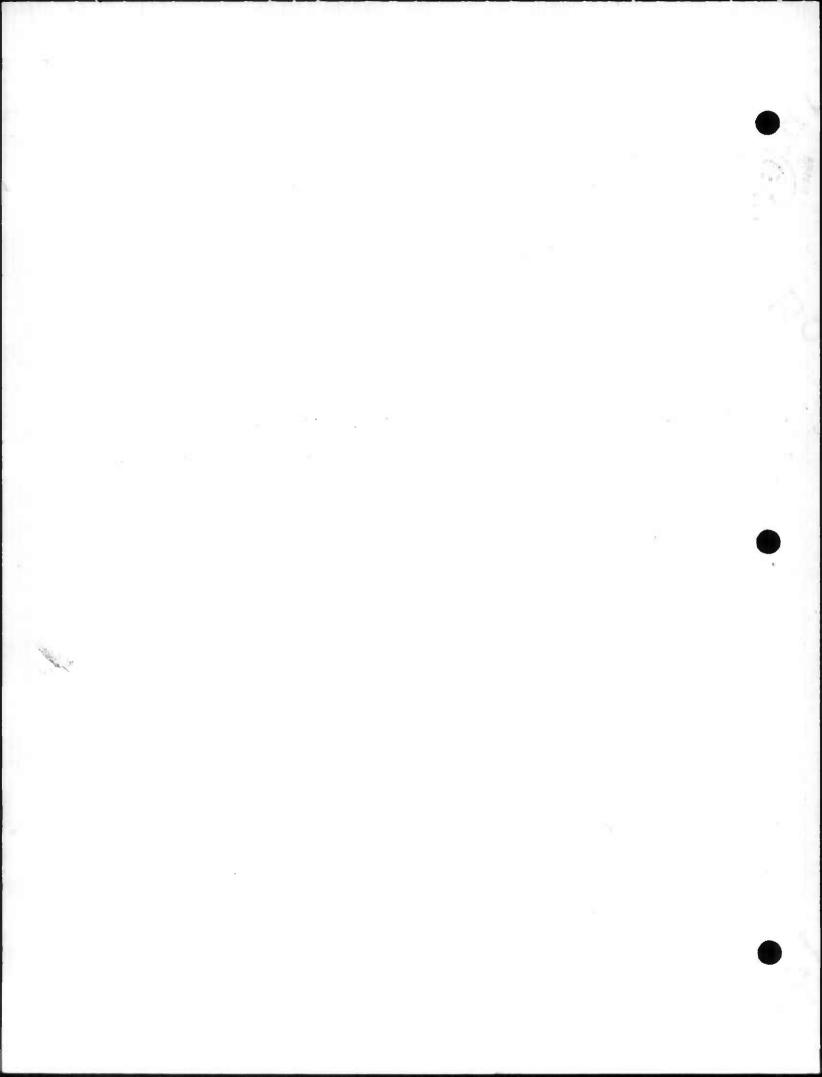
b.,

32 REGISTRAR'S SIGNATURE

Don H. Yablonowitz, M.

31. DATE FILED (Month, Day, Year)
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10300 Greenbelt Road, #101, Seabrook, MD 20706-2220



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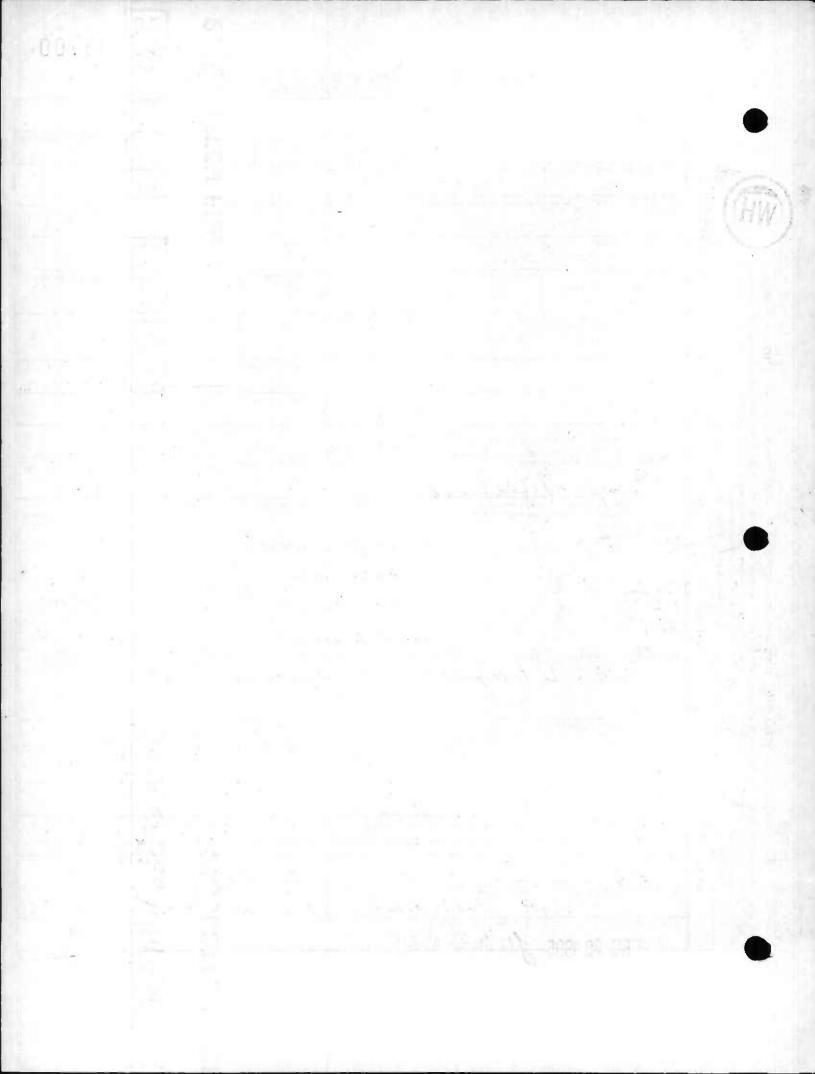
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DIVISION OF VITAL RECORDS, P.O. BOX 88760	8	SHIC	OUL	The The
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wit	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remove	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Ethel Halli-fax M. 23:00 PM 30 995 JAN. 7. DATE OF BIRTH
(Month, Dev. Year)
MARCH 26, 1903
New York 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 91 579-09-4042 1 M 2 F 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR Washington Adventist Hospital Takoma Park Montgomery RESIDENCE OF DECEDENT 10b. COUNTY IDC. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Montgomery Maryland Takoma Park 1 YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8000 Greenwood Ave. 20912 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yee, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 TES 2 NO Specify: Specify: white BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION pecify only highest grade comple 18b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Nurse 4 Nursing/ Health Care 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Sumeme) Hindmarch Fuller Edward Williams Susan Hopkins BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 2 Jeffery C. Hallifax 8000 Greenwood Ave. Takoma Park, MD 20912 20e. METHOD OF DISPOSITION
XX Buriel 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE ry, crematory or other place). Lincoln Cemetery Feb. 4 Donetion 5 Other (Specify) 3,1995 Brentwood, MD 21. SIGNATURE OF FUNERAL SERVICE LIP 22. NAME AND ADDRESS OF FACILITY Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, D.C. ications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, 23. PART I. Enter the diseases, shock or heart fellure. List only one cause on each line. Intervel Between IMMEDIATE CAUSE (Finel **Onaet and Death** diseese or condition cando polos reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): ARVKE CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury 59 DUE TO (OR AS A CONSEQUENCE OF) thet initieted events resulting in deeth) LAST PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part 1. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO npetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DEŞCRIBE HOW INJURY OCCURED 1 Natural M 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end menner ee stated. (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. 29b. SIGNATURE AND TITLE OF 29c. LICENSE NUMBER BE 29d. OATE SIGNED (Month, Day, Year) D10298 2 DEATH (ITEM 27) (Type, Print) Sandotrom My Carroll AV Takema Page, MA 31. DATE FILED (Month, Day, 32. REGISTRAR'S SIGNATURE DHMH-16 Rev 1/89

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by 1	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely make in the funeral director, page 5 should be	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

2

											9:	0	04/01	
	FOR 1 - STATE REGISTRAR	STATE OF M		D / DEPA						GIENE				
	1. DECEDENT'S NAME (First, Middle, Last) Roy L.	Hi	11						2. DATE OF DEA	DAY		YEAR 95	3. TIME OF DEATN 6:40 A	
	4. SOCIAL SECURITY NUMBER 250 12 0626	5. SEX	6. AGE (In yr:		MONTH	DER 1 YEAR B DAYS	IF UNDER	MIN,	7. DATE OF BIR (Month, Day,)	fear)	022	Count	NPLACE (State or Foreign	
2	9a. FACILITY NAME (If not institution, give	street and number)			9b. C	TY, TOWH	OR LOCATI	ON OF DE	ATN	.0.1		NTY OF D		_
CIOR	Hyattsville Ma	nor				Hyati	tsvil	le			Pr	Prince George's		
PUNE	10a. STATE 10b. COUNT	TY			,	ingt			10d. INSIDE CITY LIMITS? 1 X YES 2 NO					
A.	10e. STREET AND NUMBER			101. ZIP CODE						10g. CITIZEN OF WHAT COUNTRY?			_	
UNEX	6401 - 7th St	.,N.W.			12			Un	nited States					
1 L	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	X YES 2	NO	1	13. WAS DECENDENT OF NISPANIC ORIGIN? (Speciff yea, specify Cuban, Maxican, Puarto Rican, etc. 1 YES 2 X NO Specify:								
	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)			Give kind of the Do NOT	of work don	e during mo		ng	16b. KIND OF BUSINESS/INDUSTRY					
OMPLE	12	5+	' l	Pro	fess	or			St. Augustine College					
5	17. FATNER'S NAME (First, Middle, Last)						18. MOT	NER'S NA	ME (First, Middle, A					_
מו ע	Clarence	B. Hill							Chulla:	r Mo	Dan	iel		
5	19a. INFORMANT'S NAME (Type/Print)								loute Number, City					
-	Joyce Pegues	<u>.</u>		6401	- 7	th St	., N.	W.,	Washing	ton,	D.	C. 2	0012	
	20a. METNOD OF DISPOSITION 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Ran 4 ☐ Donation 5 ☑ Other (Specify)		20b. PLA cemetery QU	CEANDDAT	e of bisp o ther plead o Na	osition/Na Eiona	1 Ce	m. 2	DATE 2				VA .	
1	21. SIGNATURE OF FUNERAL BETTACE L	CENSEE	. /			2. NAME AI						<u></u>		_

22. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest,

CARDIORESPIRATORY FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

IMMUNE PARALYSIS

DUE TO (OR AS A CONSEQUENCE OF):

PNEUMONIA

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE ANEMIA, LEUKOPENIA, WASTING SYNDROME, ASPIRATION 1 TYES 2 NO 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) HOSPITAL OTHER:
4 Nursing Nome 5 Residence 8 Other (Specify) 1 TYES 2 NO 1 - Inpatient 2 - ER/Outpatient 3 - DOA 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF GEATN 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE NOW INJURY OCCURED 1 X Natural 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, farm, street, lactory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be 4 Nomicide 29s, CENTIFIER

ACQUIRED IMMUNE DEFICIENCY SYNDROME

McGuire Funeral Service Inc.

7400 Georgia Ave., N.W., Wash., D.C. 20012

1 🔀 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner as stated.	
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause	(a)

29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

D01499

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 377 (Type, Print)

ck, or heart fellure. List pnly one ceuse on each line.

IMMEDIATE CAUSE (Find

Sequentially list conditions,

If sny, leading to immediate cause. Enter UNDERLYING

CAUSE (Disease or Injury

thet initiated evente resulting in deeth) LAST

disesse or condition resulting in death)

Lewis Dennis, M.D., 6201 Greenbelt Rd. Ste. #Ul, College Park, MD. 20747 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

FEB 01 1995

Julia Davidson Rendall

DNMH-18 Rev 1/89

1/26/95

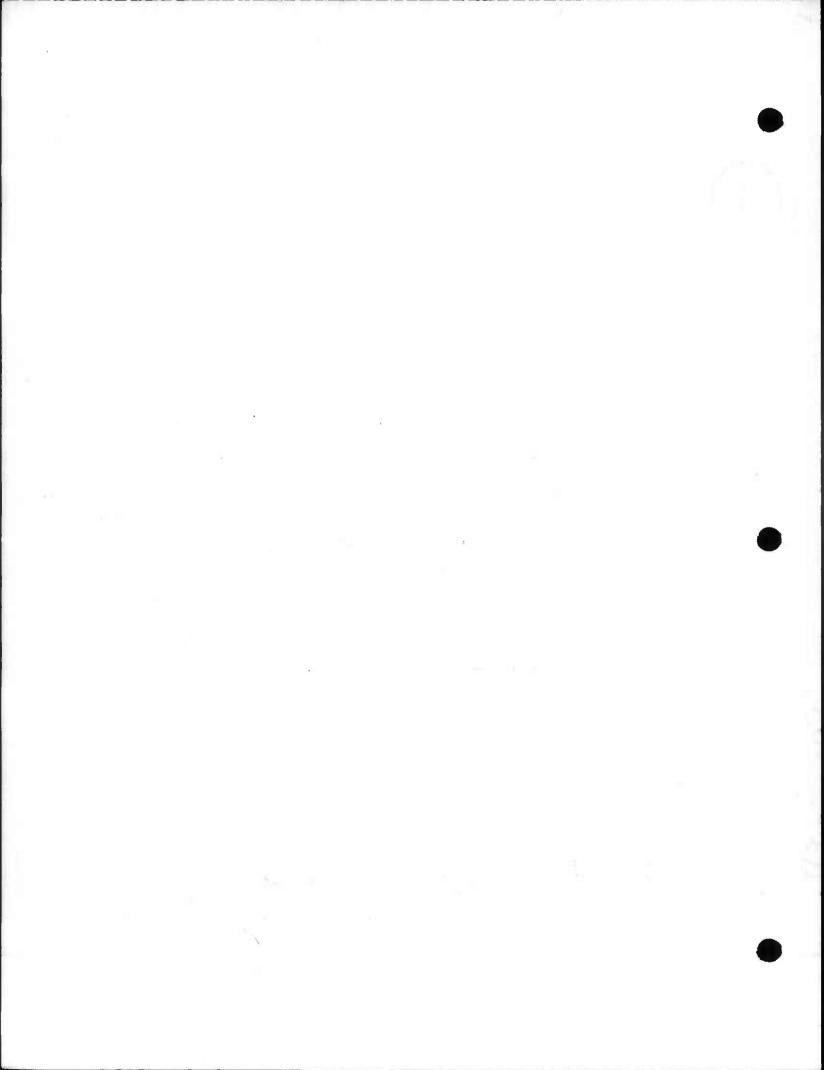
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DIRECTOR

FUNERAL

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CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

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31. DATE FILED (Month, Day, Year)

JAN 25 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

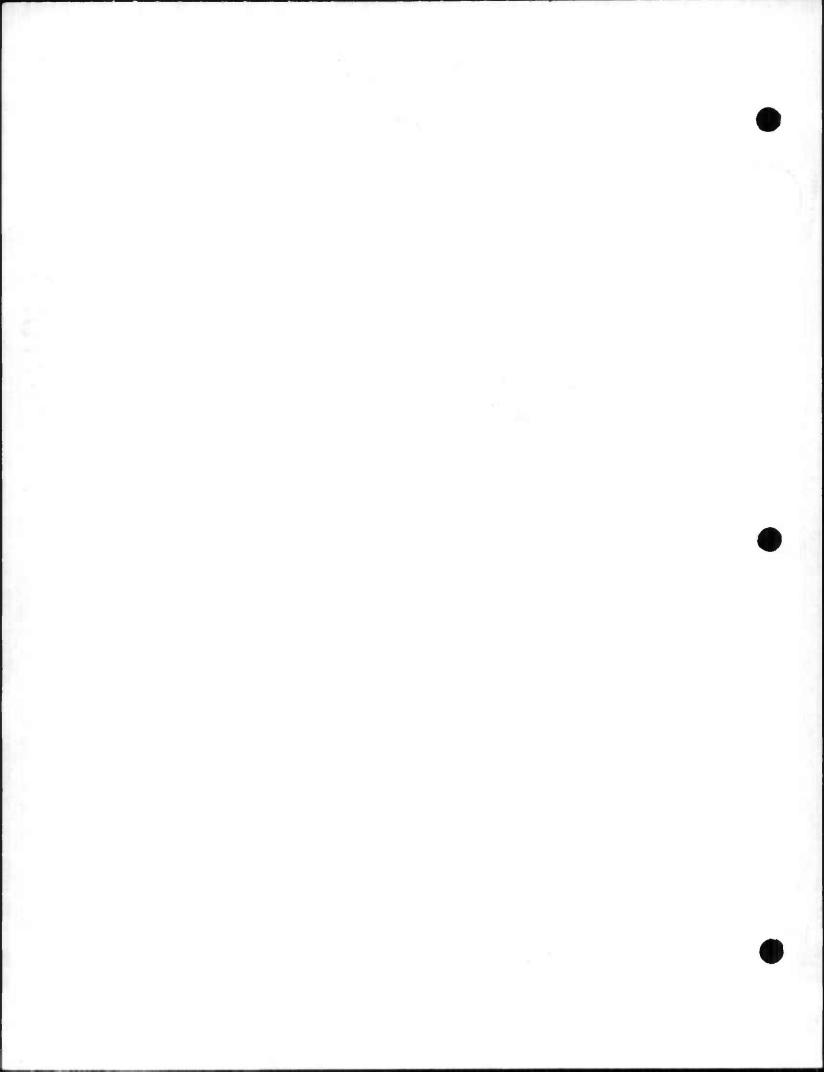
32. REGISTRAR'S SIGNATURE

Julia Davolson Revolath

n by the funeral director, page 5 should be detached for use as the burial-transit removal. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 ours after death. filled in by t 0 completely filled DIVISION OF VITAL RECORDS, P.O. BOX 68760 requires that the death certificate be executed with and com attending physician a ental Hygiene prior to prior to signed by the atter Health and Mental has been Dept. of I HOSPITAL OR ATTENDING PHYSICIAN: The law certificate the the State the with t After the L DIRECTOR: A TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 M Amended#/#/#17 #19

1 - FOR STATE OF MARYLAND / STATE OF MARYLAND / C STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2, DATE OF DEATH 3. TIME OF DEATH Hoffman Hoffmann Reinhold Wilhelm 1995 9:30 January 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 383-20-0954 1 K M 2 | F 86 DAYS Germany October 23,1908 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 10030 Tenbrook Drive Silver Spring Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Montgomery Silver Spring 1 X YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 10030 Tenbrook Drive 20901 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. RACE — American Indian, Slack, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 2 X NO 1 Never Married 2 Married 1 TES 2 NO Specify: Specify: White 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Language Professor Education 5+ 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Hoffmann Johann Adolf Hoffman Maria Lehnert 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOFF Caecilia Maria Hoffman 10030 Tenbrook Drive Silver Spring Md. 20901 On. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Sista 1 N Burial 2 Cremation 3 ... 4 Donation 5 Other (Specify) Buriel 2 Cremation 3 Re Gate of Heaven Cemetery 1/2/7/95 Silver Spring, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. Cer 500 University Blvd.W. Sil.Spr.,MD 20901 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List pnly one cause on each line interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Congestive Heart Failure resulting in death) DUE TO (OR AS A CONSEQUENCE OF): 3 Months Arteriosclerotic Heart Disease Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other aignificant conditions contributing to death but not resulting in the undariying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{\text{V}}\) 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 - YES 2 X NO 1 | Inpatient 2 | ER/Outpetient 3 | DOA ng Home 5 X Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 1 YES 2 NO Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Yown, State) 8 Could not be datarmined 4 Homicide 29a. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SUMATURE AND TITLE OF CERTIFIES 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER Samo Dajurso 4. D13548 ▶January 23, 1995

Rajindra K. Sarin, M.D. 9801 Georgia Avenue Silver Spring, Maryland 20902-5276



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 r	BALTIMO after death. Page 6 r
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director be filed within 72 hours after death with the State Dept. of Health and Mertal Hygiene prior to burial, cremation, or removal.	he funeral director al.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner mus	examiner mu

PHYSICIAN:

BY

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1 Natural

2 Accident

3 Suicide

4 Homicide

		1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.												
		1. DECEDENT'S NAME (First Fave Isikot									2. DATE 0 MONTH Janua	F DEATH	, 19	YEAR	3. TIME OF DEATH 3. A.	
		4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In)	yrs. lest birthday)	JE UNI	DER 1 YEAR	IF UNDER	R 24 HRS.	7. DATE O	Z DATE OF BIRTH		8. BIRTH	PLACE (Stetn or Formian	
		213-34-4379	9	1 □ M 2 🔀 F	8	O YRS.	MONTH	B DAYE	HOURS	MIN.	Dec 2	Day Year) 19	Land			
TAILE		9s. FACILITY NAME (If not in	nstitution, give :	street and number)			9b. C	ITY, TOW	N OR LOCATI	ION OF DE			EATH			
(WH:)	O.	Suburban Ho	ospita	1			Ве	thes	sda				Mon	tgom	ery	
64	5	RESIDENCE OF DEC	10b. COUNT			1.0		N OR LOC								
	DIRECTOR	Florida		Beach		10c. CI									10d. INSIDE CITY LIMITS?	
permit.	1	10e. STREET AND NUMBER		Deach			Der		Beach				40-017		VES 2 NO	
5	FUNERAL	7185 Huntir	ngton :	Lane					3344	_			USA	ZEN OF W	HAT COUNTRY?	
:1215-0020 or attending physician. r use as the burial-transit	В	11. MARITAL STATUS 1 Never Merried 2 3 3 Wildowed 4 Divo	-	12. WAS DECEDED FORCES? IF YES, GIVE 1	1 YES	2 XNO	1	If yes,	ECENDENT (specify Cube ES 2 NO	en, Mexicai	n, Puerto Ric	(Specify Yee cen, etc.)	or No-	14. RACE Black Spech	- American Indian, , white, etc. by: White	
BALTIMORE, MARYLAND 21215-0020 or death. Page 6 may be retained by the hospital or attending physic the funeral director, page 5 should be detached for use as the burial at must be notified at once.	COMPLETED	15. DEC (Specify onl Elementary/Secondary (C 1.2	EDENT'S EDU y highest grade 3-12)	CATION completed) College (1-4 or 5		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of with. Do NOT use retired.) HOUSEWIFE				ing	165. KIND OF BUSINESS/INDUSTRY HOUSEWife					
ANE the hosp detache	×	17. FATHER'S NAME (First, M	fiddle (est)			по	usev	vire								
MARYLAND 2- retained by the hospital of 5 should be detached for notified at once.	BE CC	Jacob Lynn	noole, Lesty									erling				
MAR retained 5 should notified	2	19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)														
be re	-	Sharon Gottlieb 8708 Wandering Trail Drive, Potomac MD 20854												0854		
ALTIMORE, ideath. Page 6 may be funeral director, page 1.		20s. METHOD OF DISPOSIT 1 X Burlel 2 Cremetic 4 Donation 5 Other	n 3 🗆 Rem	oval from State	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetery or other piece) King David Memorial Gardens1/27 Falls Church											
BALTIN rours after death. Page of in by the funeral dir or removal.		21. SHOKATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Direction														
BA after de by the fu moval.	Щ	Ele	ul	Jece											D 20852	
		23. PART I. Enter the d ahock, or h IMMEDIATE CAUSE (Fir	eart failure.	complications the List only one car	nt caused thuse on eech	ne death. Do n iina.	not ent	er the n	node of dy	ing, auch	as cardie	c or reapi	retory arr	eat,	Approximata interval Between Onset and Deat	
tely fi		disease or condition reaulting in death)	→	Bilate	eral P	neumon	ia								1 Day	
d within				DUE TO	(OR AS A CO	ONSEQUENCE (OF):								-	
ECORDS, P.O. BOX 68760 quires that the death certificate be executed within an signed by the attending physician and completely fills if Health and Mental Hyghene prior to burial, cremation, towas any Injury, or other traumatic event, the	CERTIFICATION	Sequentially list condition if any, leading to immecause. Enter UNDERLY!	diate ING	с		ONSEQUENCE (
SS, P.O. BOX be death certificate be en the attending physicien a Mental Hygiene prior to njury, or other traum	CERTIF	that initiated events resulting in death) LAS	1	d		ONSEQUENCE C										
the of the old Me injur			PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert i. 24s. WAS AN AUT											24b.	WERE AUTOPSY FINDINGS	
ECORDS, quires that the de n signed by the af if Health and Ment tows any Injury.	MEDICAL	Metastatic										PERFOR			AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
E Squirr	M	Hypertensia	ve and	Arterio	sclerc	tic Ca	rdic	ovas	cular	Dise	ase		1 TES 2 NO			

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 Nopelient 2 ER/Outpetient 3 DOA OTHER: 1 TYES 2 NO

4 - Nursing Home 5 - Residence 8 - Other (Specify)

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

▶ 1/25/95

27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 5 Pending Investigation 1 YES 2 NO

28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 6 Could not be

29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and place, and due to the cause(a) and menner as stated.

2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

D07285

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

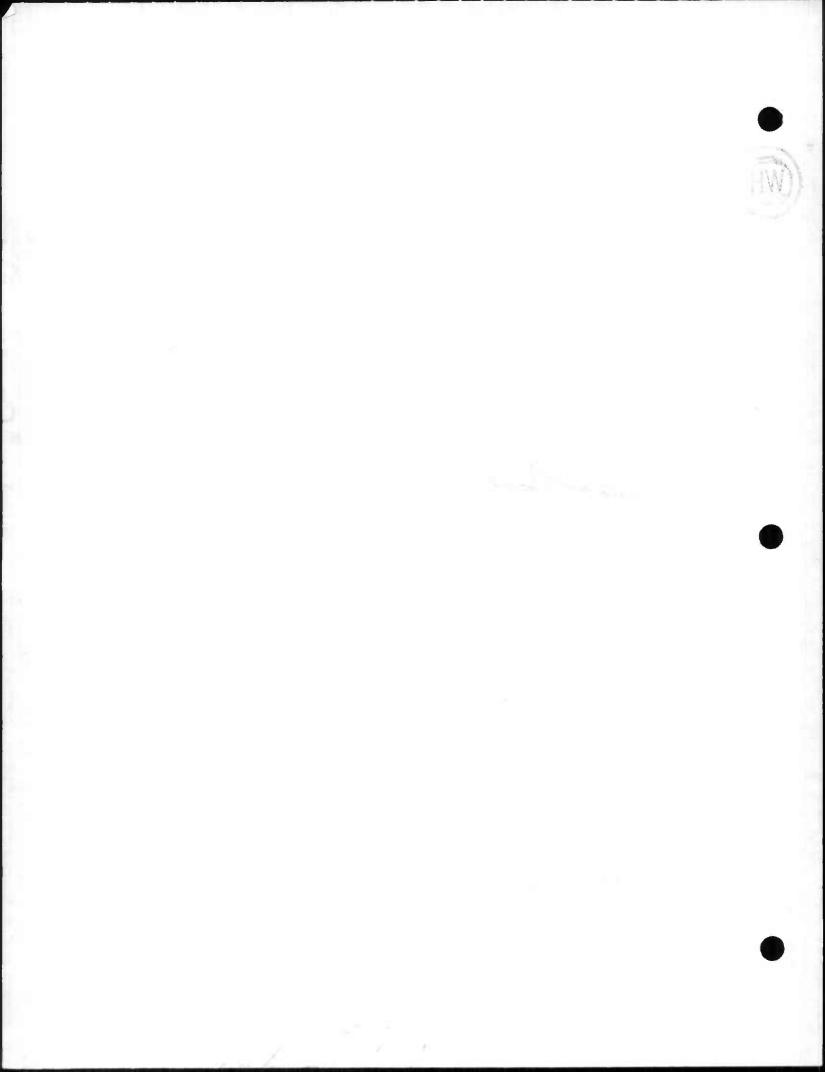
9709 Medical Center Drive, Rockville, MD 20850 M.D. James A. Brown,

31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

4.

DHMH-18 Rev 1/89

1 - YES 2 1-NO



TO BE COMPLETED BY FUNERAL DIRECTOR

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2

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Amended 7	+ ,	10g =	#/	196		1.7	/		100	_ /	11	1	- 0.0	Cta		
FOR 1 - STATE	,	STATE OF M	ARYLA	AND /	DEPART	MEN	T 01	HEALTH	AND	MENTAI	L HYGIE	NE	ner	1 . 9.		
REGISTRAR								F DEA	TH		REG. N	5	0			
1. DECEDENT'S NAME (First, Middle, L	nst)	Seebert			Ingra	m				2. DATE MONTH		DAY,	YEAR	3. TIME OF DEATH		
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. list birthdey) If UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLAC												IPLACE (State or Foreign				
(A) 26 1520 (VI) N 2 F 90 MONTHS DAYS HOURS MIN. (Month, Day, Year) Country)											West Virgini					
9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUN													Y OF DEATH			
Holy Cross Hosp		L				Sil	ve	r Spri	ng			Mot	ntgom	ery		
10e. STATE 10b. CO					10c. CITY,	TOWN	OR LC	CATION						10d, INSIDE CITY		
Mar Ohio	E	Richland	l		Sì	nelb	У							LIMITS?		
100. STREET AND NUMBER 170 West Park R	oad							101. ZIP COD				10g. Cl	TIZEN OF Y	WHAT COUNTRY? USA		
11. MARITAL STATUS 1 Never Merried 2 Merried	12	. WAS DECEDENT	EVER IN	U.S. ARA	MED			DECENDENT				ee or No-	14. RACI	E — American Indian,		
3 X Widowed 4 Divorced		IF YES, GIVE W					1 🗆	YES 2 NO	Specif	fy:	noun, etc.y		Spec	E — American Indian, k, White, atc. My: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KIND OF BUSINESS/INDUSTRY																
Elementery/Secondary (0-12) College (1-4 or 5+) 12 College (1-4 or 5+) Tool and Die Maker Machinery																
17. FATHER'S NAME (First, Middle, Last								18. MOT	HER'S NA		Aiddle, Maide					
John Miles Ingr	am									e Sta						
190. INFORMANT'S NAME (Type/Print) Wincel Ingram								el and Numbe				Toy,	Ohio	44875		
20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremetton 3 X 1 4 Donatton 5 Other (Specify)	lemova	from State			NO DATE OF				1	/30/0	20c. L	OCATION -				
21. SIGNATURE OF FUNERAL SERVICE			Joa	KIGI	ia ce	22.	NAMI	E AND ADDRE	SS OF FA	CILITY						
Jinothy	D	Can	phi	W		5	00	Unive	ersit	ty B1	vd. W	. Si	l.Spr	, Inc. .,MD 20901		
23. PART i. Enter the diseeses, ahock, or haert fallo	or com	plications that Dnly Dne ceu	caused se Dn ee	the dec	eth. Do no	t enter	the	mode of dy	ing, auc	ch ea cerd	llec or res	piratory a	rrest,	Approximate intervel Between		
iMMEDIATE CAUSE (Finel disease or condition				1.1			1							Onset and Death		
reaulting in death)	0,	DUE TO	OR AS A	CONSEO	UENCE OF	52	10		I A					umdial		
	ь		. /	1/1	ita	dra	h	ch	08/1	ita	()11	011		121441		
Sequentieily list conditions, if any, leading to immediate	-	DUE TO (OR AS A	CONSEO	UENCE OF)	:		-	000	,,,,	SOV		1	9000		
CAUSE (Disease or injury	c	DUE TO	A SA BO	CONSEC	UENCE OF)											
that initiated events resulting in death) LAST		502 10 (On AS A	CONSEC	DENCE OF	•										
DART II ONLY II III	a															
PART II. Other algnificent condi	tions c	Dotributing to	daath bu	it not re	suiting in	the ur	nderi	ying ceuse	given in	Part I.		N AUTOPSY PRMED?	24b	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO		
				-						-	1 TES	2 0 NO		COMPLETION OF CAUSE OF DEATH?		
					•					$-\parallel$				1 YES 2 NO		
25. WAS CASE REFERRED TO MEDICA EXAMINER?							28	PLACE OF E	DEATH (Ch	eck only on	e)					
1 TYES 2 NO		OSPITAL:	ER/Outpe	itlent 3		OTHER		lome 5 🗆 R	eeldence	6 🗆 Other	(Specify)					
27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigati	on	28e. DATE OF I	NJURY y, Ybar)		28b. TIME INJU			INJURY AT WORK? YES 2	NO NO	28d. DE\$	CRIBE HOW	INJURY O	CCURED			

28e. PLACE DF INJURY — At home, term, street, tectory, office building, etc. (Specify) 28t. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be determined 4 Homicide 29e. CERTIFIER 1 🕱 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ea stated.

29b. SIGNATURE AND TITLE OF CENT

29c. LICENSE NUMBER D 33 293 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

mitt - 5 401 - W 32 REGISTRAR'S SIGNATURE Julia Davidson hardalle Rue NW WAShington

31. DATE FILEO (Month, Day, Year)

JAN 31 1

.5

29d. DATE SIGNED (Month, Day, Year)

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H				
	1. DECEDENT'S NAME (First, Middle, Last) Harold Pinkne	ey Jones				MONTH	5 199	EAR 405 AM
	0	ØM2□F 7	n yrs. lest birthdey) 7 YRS.	IF UNDER 1 YEAR MONTHS DAYS	# UNDER 24 HRS. HOURS MIN.	Jan. 25, 1	917 M	BIRTHPLACE (State or Foreign Country)
TOR	Magnolia Hall Nu			Cheste		DEATH		
DIRECTOR	10e. STATE 10b. COUNTY MD Kent			r, TOWN OR LOCA NESTER TO				10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	106. STREET AND NUMBER 7532 Quaker Nec	k Road		10	1. ZIP CODE 21620			
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	If yes, sp	ecify Cuban, Maxic	an, Puerto Rican, etc.)	Yea or No — 14.	Black, White, etc. Specify:
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12) 0]	ON spieted) college (1-4 or 5 +)		USUAL OCCUPATION OF COMPANY OF CO	ON ost of working			
M	17. FATHER'S NAME (First, Middle, Leet)		Barber		Las recoverage			
	James A. Jone	S				_ ' ' ' _ '	Shop Some Surrame 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian Black, White, etc. Specity: Black USINESS/INDUSTRY Shop In Surrame) af Surrame Approximate interval Bet Oneet and Is COUNTRY I piratory arreat, Approximate interval Bet Oneet and Is COUNTRY APPROXIMATION OF CAMPLETION	
BE	19a. INFORMANT'S NAME (Type/Print)		19b, MAILING	ADDRESS (Street)				(a)
٩	Nora D. Jones							
	20e. METHOD OF DISPOSITION 1 X Burlet 2 Cremetion 3 Removel 4 Donetion 5 Other (Specify)	from State cem	PLACE AND DATE Of etery, cremetory or of Danes Cen	OF DISPOSITION (Na	ame of	DATE 20c.	LOCATION — City	or Town, State
	21. SIGNATURE OF TUNERAL SERVICE LICENS		C C	22. NAME AI	ND ADDRESS OF F	ACILITY Walle	v Funer	al Home
	Sennos	t wa	laz	Che	stertown	, MD 2162	0	
	shock, or heart fellura. List iMMEDIATE CAUSE (Fins) disease or condition resulting in death)	DUE TO (OR AS A	the death. Do not line. Letter CONSEQUENCE OF	PM	1			interval Between
CERTIFICATION	Sequentielly liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		CONSEQUENCE OF	ŋ:				
PHYSICIAN: MEDICAL C	PART II. Other significant conditions of	ontributing to death b	ut not resulting i		g cause given in	PERF	ORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
IA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PI	ACE OF DEATH (C	heck only one)		
SIC		OSPITAL: Inpetient 2 ER/Outp	atient 3 🗆 DOA	OTHER: 4 Nursing Horr	e 5 🗆 Residence	6 Other (Specify)		
ВУ РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	E OF 28c, INJ			W INJURY OCCUR	ED
	3 Suicide 6 Could not be 4 Homicide determined	26s. PLACE OF INJURY building, etc. (Spec	— At home, ferm, s	treet, factory, offic	0			Pural Ploute Number,
COMPLETED	1111							suse(a) and manner ee stated.
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	an P	Moss		010	2. DATE OF DEATH JANUARY 5 1995 2. DATE OF BEATH JANUARY 5 1995 2. DATE OF BEATH JANUARY 5 1995 2. DATE OF BEATH JANUARY 5 2. DATE OF BEATH JOHN MM. 2. DATE OF BEATH JOHN JANUARY 5 2. DATE OF BEATH JOHN JANUARY 5 2. DATE OF BEATH JOHN JANUARY 5 2. DATE OF BEATH JOHN JANUARY 5 2. DATE OF BEATH JOHN JANUARY 5 3. TIME OF BEATH Country) MD 3. TIME OF BEATH Country) MD 3. TIME OF BEATH Country) MD 3. TIME OF BEATH JOHN JANUARY 5 4. BISTURD ACC Country) JOHN JANUARY 5 JOHN JA		
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	0-10	ding	s the	

hours after death. Page 6 may be retained by the hospital or attened in by the funeral director, page 5 should be detached for use as BALTIMORE, MARYLAND 2121 pe completely filled in by rial, cremation, or remo HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with signed by the attending physician and con Health and Mental Hygiene prior to burial, shows any t. of H has be Dept. 23 THE HOSPITAL OR ATTENDING PHYSICIAN: The THE FUNERAL DIRECTOR: After this certificate I fled within 72 hours after death with the State 0 marked, Item 28 TO THE HOSPITAL OF THE FUNERAL DE DE FIED WITHIN 72 H

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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or other

CERTIFICATION

PHYSICIAN: MEDICAL

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COMPLETED

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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ebruary James Vernon Johnson, Sr. 2:48 P 7. DATE OF BIRTH (Month, Day, Year) Jan. 4, 1922 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 217-12-2528 HOURS Maryland 1 X M 2 - F 73 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Montgomery General Hospital Olney Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Damascus 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 26300 Howard Chapel Drive 20872 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puarto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 K Married ВУ 3 Widowed 4 Divorced W.W.II White COMPLETED 15. DECEDENT'S EDUCATION

All only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION

The kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 10 Contractor Masonary 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William E. Johnson Gertrude C. Poole BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 26300 Howard Chapel Dr., Damascus, Md. 20872 Mary L. Johnson 20a. METHOD OF DISPOSITION

| Burlal 2 | Cremation 3 | Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State ery, cremetory or other place). Mountain View 2/11/95 4 Donation 5 Other (Specify) Damascus, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth, P.A. olasu 261101 Ridge Rd., Damascus, Md. 20872 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate shock, or heart failurs. List only one cause on each line. interval Batween IMMEDIATE CAUSE (Final **Onset and Death** disease or condition_ resulting in death) 6 hours 20 Years Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events abeler Years resulting in death) LAST 20 PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO W UNCERTAIN I 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Xinpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 TES 2 NO 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner es stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUM 1995 ESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Olney-Sandy S nristopher Md hemm 20832 neu

32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		1 - STATE REGISTRAR	CERTI	FICATE OF	DEATH	REG. NO.		
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		4. SOCIAL SECURITY NUMBER 5. SEX 6. AG	SK.	Jone	<u>ک</u>	FEB. O.		2201 M
		190-15-07/6/2 1 M 2 D F	E (In yrs. last birthday	MONTHS DAVE	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	1910 Sol	THPLACE (State or Foreign
~		9e. FACILITY NAME (if not institution, give street end number)	18		OR LOCATION OF DE	ATH	9c, COUNTY OF	ORK COLYB.
	S O	DEATON HOSP + H	CME	Bal	TIMO		49	MORE CO.
(WH))	2	RESIDENCE OF DECEDENT 106. STATE 106. COUNTY		CITY, TOWN OR LOCAT			073	
	DIRECTOR	Pa. YORK	100.0	YORK (774			10d. INSIDE CITY LIMITS? 1 TES 2 NO
-		10. STREET AND NUMBER			. ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?
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020 physician. burial-transit	J.	11. MARITAL STATUS 1 Never Merried 2 Married 12. WAS DECEDENT EVER	S 2 1 NO	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yes	Bi	CE — Americen Indian, ack, White, etc.
D iji	B	3 Widowed 4 Divorced IF YES, GIVE WAR OR	DATES	1 TYES	2 July Specify	r.	Sp	BLACK
	8	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give kind o	'S USUAL OCCUPATION work done during mo	ON set of working	16b. KIND OF BUS	SINESS/INDUSTRY	22701
\$ E 10	COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT	use retired.)	11/	1. 10)	= ÷ 1 1 1 1
AND. the hospil detached	N P	17. FATHER'S NAME (First, Middle, Last)	CUNS	rikucii.	ONUJOR	ME (First, Middle, Meiden	LASTE	-RING
YLA by the be de	E C	MITCH F. LONES	2		18. MUTHER'S NA	ME (First, Middle, Meiden	Surname)	OBTAN
MARYLAND 21 retained by the hospital or 5 should be detached for untilfied at once.	0 8	19e. INFORMANT'S NAME (Type/Print)	196, MAILIF	NG ADDRESS (Street a	and Number or Rural I	Poute Number, City or Town	n, State, Zip Code)	GK 10-
60 40	۲	ETHELLIVENES	440	9 E.KL	NGST.	YORK!	Pa. 17	403
ORE, 6 may be ector, page must be		1 Buriel 2 Cremation 3 Removal from State	equetery, cremetory or	E OF DISPOSITION (Na	ame of	DATE 306 LO	CATION — City or	Town State
- 00		4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	MISCHET	The state of the s	ND ADDRESS OF FA	ROUS	YORK,	Va.
ALTIMORE, death. Page 6 may b funeral director, page		> 6 has 9 fel				Chas. E. Lebe	r Funeral Pa York, PA 17	riors 7404
B after by the smova		23. PART I. Entar tha diseasea, or complications that cause	ad the death. Do	not anter the mo				Approximata
or in or		shock, or heart failura. List only one cause on IMMEDIATE CAUSE (Final	aach ilna.					Interval Batween Onset and Death
with with rpletely fille cremation,		disease or condition a. ONG	ESTIV	IE HE.	ART	FAILU	RE	12-34Rs
68760 eccuted with and completel burial, crema		DOE TO (OR A	A CONSEQUENCE	OF):	10M401	0		7 5415
secure and and burnatic	ON	Sequentially list conditions, DUE TO (OR AS	S A CONSEQUENCE		ION TO	MAA		4-2 (10)
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o.O. B noting phy Hygiene p	E	that initiated events resulting in death) LAST	A CONSEQUENCE	OF):				
H 5 0 -	CER	d						
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SOR es that gned b safth an	<u> </u>	DIAGETES MERCITUS.			CAR DI	1 UYES 2	NO	COMPLETION OF CAUSE OF DEATH?
RECC requires seen signo of Healt	. ME	METASTATTE PROSTATE			1	-4	'\	1 TYES 2 NO
> 0 -	A	DID TOBACCO USE CONTRIBUTE TO CAUSE 25. WAS CASE REFERRED TO MEDICAL		ATH (Check only one)	UNCERTAIN	N DA		
F = = = 5	HYSICIAN	EXAMINER? 1 YES 2 NO 1 Nopportent 2 ER/O		OTHER:	e 5 🗆 Raeldence	8 Other (Specify)		
T S S T	F	27. MANNER OF DEATH 28s. DATE OF INJUR	Y 28b. Ti	IME OF 28c, INJ		28d. DESCRIBE HOW II	NJURY OCCURED	
ON OING PHYS After this death with	BY	1 Pending 2 Accident Investigation		M 1 🗆 Y	res 2 🗌 No			
0 0 4 0 0	8	3 Suicide 8 Could not be determined 28s. PLACE OF INJU building, etc. (S)	RY — At home, ferm pecify)	, atreet, fectory, office	•	281. LOCATION (Street e City or Town, Stete)	nd Number or Rura	l Route Number,
DIVISION OR ATTEN DIRECTOR: hours after Item 28 i	E	20a CEDTIFIED V						
	COMPL	(Check only One) Check only One) Check only One) MEDICAL EXAMINER: On the basic of examinating the control of the basic of the basic of examinating the control of the basic of examinating the control of the basic of the bas						o(a) and manner as stated
HOSPITAL FUNERAL WITHIN 72		29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUM			ED (Month, Day, Year)
TO THE HOSPITAL TO THE FUNERAL Be filed within 72 IMPORTANT: If	BE	1 Sin Cowaller	0-		-			
=	2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF I	DEATH-(ITEM 27) (Ty)	De, Print)	A			MD 21230
		BRIAN C-WALLACE	M) 61	115.CH	ARL(S	5. BALT	mores	MD 21230
- 2		31. DATE FILED (Month, Day, Year) 22. REGISTRAR'S SK	NATURE /					′

a Man Anne

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

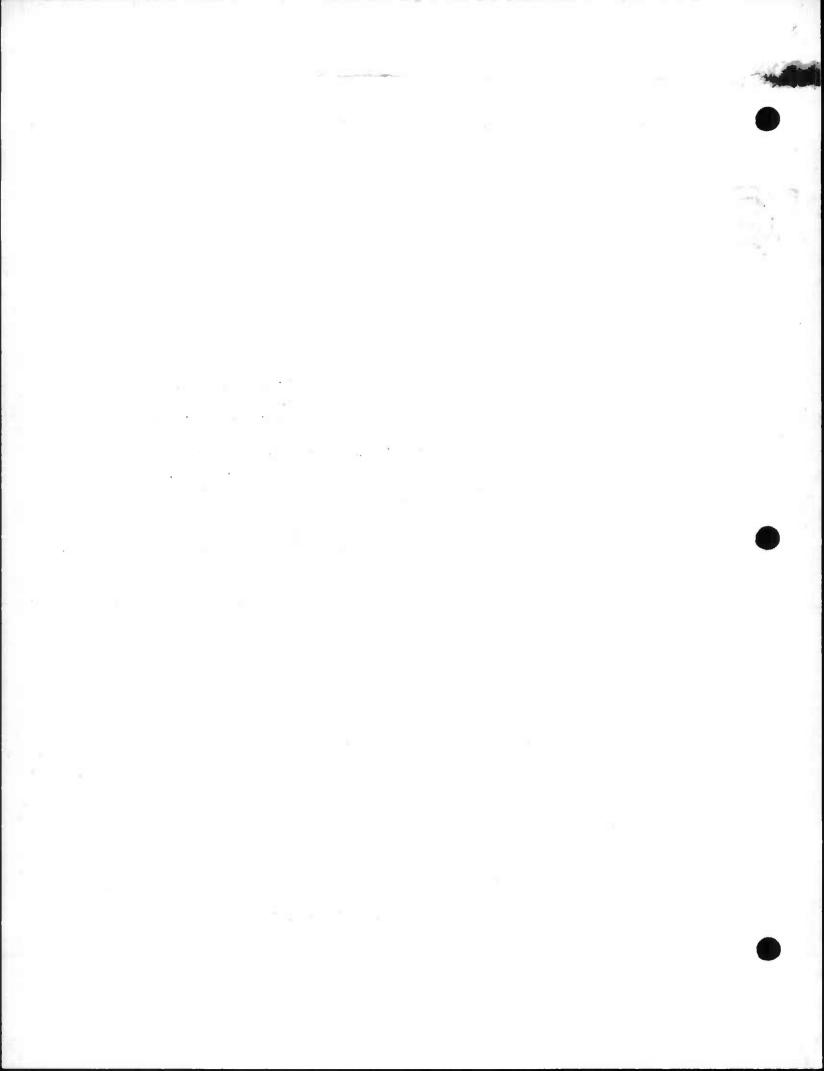
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

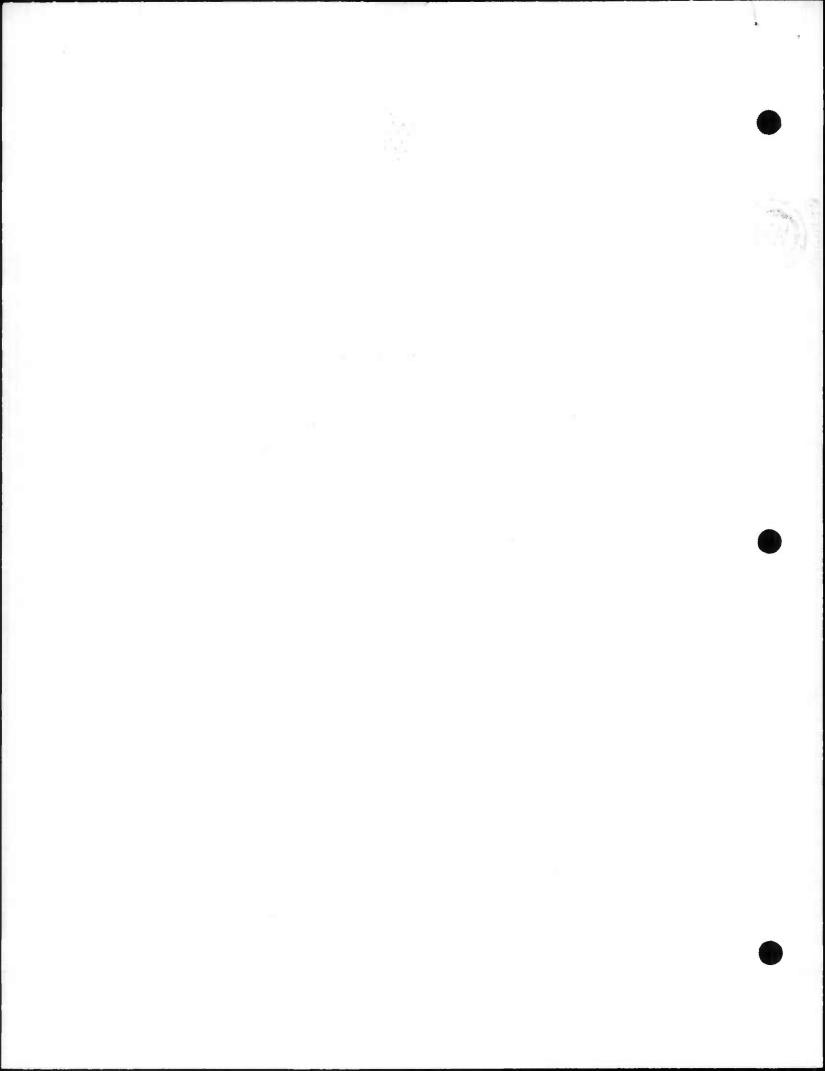
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ANCELA CECELTA JOHNSON PERSONAL SECURITY NAMES AND ALL PROPERTY AND ALL PR		1. DECEDENT'S NAME (First, Middle, Last))								E OF OEATH			3. TIME OF DEATH
A SOCIAL SCURITY MARREY 2.14 - 74 - 75 - 330		ANGELA	CECEL	IA		JOHN	SON							06:00 A M
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196. MALING ADDRESS (Street and Number or Rate Room Number, City or Sum, State, Ze Cody) Margaret L. Stevenson Route 4 Box 551; Luray, VA 22835-9653 Route 180. Decided or Disposition (State and Number or Rate Room Number, City or Sum, State, Ze Cody) Route 4 Box 551; Luray, VA 22835-9653 Route 4 Box 551; Luray, VA 22835-9653 Route 5 Box (State and Number or Rate Room Number, City or Sum, State, Ze Cody) Route 5 Box (State and Number or Rate Room Number, City or Sum, State, Ze Cody) Route 6 Box (State and Number or Rate Room Number, City or Sum, State, Ze Cody) Route 6 Box (State and Number or Rate Room Number, City or Sum, State, Ze Cody) Route 6 Box (State and Number or Rate Room Number, City or Sum, State, Ze Cody) Route 6 Box (State and Number or Rate Room Number, City or Sum, State, Ze Cody) Route 6 Box (State and Number or Rate Room Number, City or Sum, State, Ze Cody) Route 6 Box (State and Number or Rate Room Number, City or Sum, State, Ze Cody) Route 6 Box (State and Number or Rate Room Number, City or Sum, State, Ze Cody) Route 6 Box (State and Number or Rate Room N	EC	George Bernard	d McDermo	tt									oerge	er)
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23. PARTY Enter the disease, or confplications that coaled the diseash. Do not enter the mode of dying, such as certified present failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease), or condition resulting in death) DUE TO (OR AS A CONSCOUENCE OF): Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING CAUSE (Pisease or Injury that initiated evente resulting in death) DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE OF): C. DUE TO (OR AS A CONSCOUENCE			ICENSEE /	1 O COM	7	22.	NAME AN	D ADDRES	SS OF FA	CILITY				
INMEDIATE CAUSE (Final death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (O		Cumberland, MD 21502												
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury Due TO (OR AS A CONSEQUENCE OF): Due To (OR AS A CONSEQUENCE OF): Due To (OR AS A CONSEQUENCE OF):		IMMEDIATE CAUSE (Finel disease or condition	a. Car	CINOM	a	of						etory ar	rest,	Interval Between
PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuee given in Pert I. 24a. WAS AN AUTOPSY PERPORMED? 24b. WERE AUTOPSY PERPORMED? 1	CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evente DUE TO (OR AS A CONSEQUENCE OF):												
2 Accident Investigation 28a. PLACE OF INJURY — Af home, farm, street, fectory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the baset of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 29b. Signature and Title of Certifier 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29b. Signature and Dates of Person who completed cause of Death (ITEM 27) (Type, Print) 21502						in the un	derlying	ceuee g	given in	Pert I.			24b.	
2 Accident Investigation 28a. PLACE OF INJURY — Af home, farm, street, fectory, office 28f. LOCATION (Street and Number or Bural Boute Number, City or Town, State) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the baset of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 29b. Signature and Title of Certifier 29c. LICENSE NUMBER 29d. Date Signed (Month, Day, Year) 29b. Signature and Dates of Person who completed cause of Death (ITEM 27) (Type, Print) 21502	5	Gastrobite	stral	Bleedin	8								1	COMPLETION OF CAUSE
2 Accident Investigation 28a. PLACE OF INJURY — Af home, farm, street, fectory, office 28f. LOCATION (Street and Number or Bural Boute Number, City or Town, State) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the baset of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 29b. Signature and Title of Certifier 29c. LICENSE NUMBER 29d. Date Signed (Month, Day, Year) 29b. Signature and Dates of Person who completed cause of Death (ITEM 27) (Type, Print) 21502				(
2 Accident Investigation 28a. PLACE OF INJURY — Af home, farm, street, fectory, office 28f. LOCATION (Street and Number or Bural Boute Number, City or Town, State) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the baset of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 29b. Signature and Title of Certifier 29c. LICENSE NUMBER 29d. Date Signed (Month, Day, Year) 29b. Signature and Dates of Person who completed cause of Death (ITEM 27) (Type, Print) 21502	ž	DID TOBACCO USE CONT	TRIBUTE TO CA	USE OF DEAT	TH YE	S 🗆 1	NO X	UNC	ERTAIN	V				
2 Accident Investigation 28a. PLACE OF INJURY — Af home, farm, street, fectory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the baset of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 29b. Signature and Title of Certifier 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29b. Signature and Dates of Person who completed cause of Death (ITEM 27) (Type, Print) 21502	S		HOSPITAL	26, PLACE	E OF DEA		,,							
2 Accident Investigation 28a. PLACE OF INJURY — Af home, farm, street, fectory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the baset of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 29b. Signature and Title of Certifier 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29b. Signature and Dates of Person who completed cause of Death (ITEM 27) (Type, Print) 21502	YSI			ER/Outpetlant 3	□ DOA			5 🗆 Ra	eldence	6 🗆 Oth	er (Specify)			
2 Accident 3 Suicide 4 Nomicide 5 Could not be determined 28a. PLACE OF INJURY — At home, farm, street, fectory, office 5 Unicide 6 Nomicide 7 Suicide 7 Suicide 7 Suicide 7 Suicide 8 Could not be determined 28a. PLACE OF INJURY — At home, farm, street, fectory, office 8 City or Town, State) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the baset of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) LIVENGOOD, PAUL T., M.D., 912 SETON DRIVE, CUMBERLAND, MD. 21502	H H	The second secon	28a. DATE OF (Month, D	INJURY Pay, Year)	28b. TIM	IE OF IURY				28d. DE	SCRIBE NOW IN.	JURY OC	CURED	
29a. CERTIFIER (Check only one) 29b. Signature And Title OF Certifier 29b. Signature And Title OF Certifier 29b. Signature And Title OF Certifier 29b. Signature And Title OF Certifier 29c. License Number 29c. License Number 29d. Date signed (Month, Day, Year) FEBRUARY 3, 1495 10 Certifier 29c. License Number 29d. Date signed (Month, Day, Year) FEBRUARY 30. Name and address of Person who completed cause of Death (Item 27) (Type, Print) LIVENGOOD, PAUL T., M.D., 912 SETON DRIVE, CUMBERLAND, MD. 21502	B					М			NO					
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE		o _ codid not be	28a, PLACE O building,	of INJURY — At hone atc. (Specify)	ne, farm,	atreet, fecto	ory, office	•				d Number	or Rural R	oute Number,
29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) FEBRUARY 3, 1495 LIVENGOOD, PAUL T., M.D., 912 SETON DRIVE, CUMBERLAND, MD. 21502	PLE	29a. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of	my knowledge, des	ith occurr	ed at the ti	me, date	and place,	and due	to the ca	ruse(a) and menn	er aa ata	ted.	
29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) FEBRUARY 3, 1495 LIVENGOOD, PAUL T., M.D., 912 SETON DRIVE, CUMBERLAND, MD. 21502	8) and manner as stated.
LIVENGOOD, PAUL T., M.D. 912 SETON DRIVE, CUMBERLAND, MD 21502	BE	296 SIGNATURE AND TITLE OF CERTIFIE Taw J. M.	versoo	emo										2 1000
31. Date Filed (Mary), Clay, Very 4005 32. Registrates because the second parties of all	-													
H TO BE SEE THE SECOND OF THE SECOND		LIVENGOOD, PAUL	T., M.D.	912 SETO	N DE	IVE.	CUM	BERL	AND.	MD	2150	2		





3.	1.		Æ	
	BALTIMORE, MARYLAND 21215-0020	24 hours after death. Page 6 may be retained by the hospital or attending physician	filled in by the funeral director, page 5 should be detached for use as the burial-transform, or removal.	he medical examiner must be notified at once.
	DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be making by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transforbe filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remove.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLANI		TMENT OF CATE OF		D MEN	TAL HYGIEN				
	1. DICEDENT'S NAME (First, Middle, Lest) 4. SOCIAL SECURITY MUMBER 2	ONNSON S. SEX & AGE (In yrs	s. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR	5 7.0	TATE OF DEATH ON ONTH ON ON ON ON ON ON ON ON ON ON ON ON ON	27,	95	TIME OF DEATN ACE (State or Foreign	
2011111	90. FACILITY NAME (If not institution, give street	ot and number)	YRS.	MONTHS DAYS	HOURS MIN		pt. 17,	L937	Mal	ryland	
TOR	Bon Secour Ho	Control of the contro			ltimor			9C. COON	T OF DEA		
DIRECTOR	100. STATE 10b. COUNTY Maryland Bal	timore	10c. CITY	Balti						Dd. INSIDE CITY LIMITS? YES 2 XNO	
FUNERAL	10. STREET AND NUMBER 329 N. Carrollt	on Ave.		10	Y. ZIP CODE 2122	3				AT COUNTRY?	
ВУ	11. MARITAL STATUS 1 1 Never Merried 2 Merried 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S. FORCES? 1 TYES 27 IF YES, GIVE WAR OR DATES	X NO	If yes, a	CENDENT OF HIS pecify Cuben, Me	kican, Pue	RIGIN? (Specify Year orto Ricari, etc.)	or No-	Black, V	American Indian, White, etc. Black	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co	TION 16e. mpleted) Coffege (1-4 or 5+)	ON ost of working		16b, KIND OF BUS		STRY				
OM	17. FATNER'S NAME (First, Middle, Last)		Homer		18. MOTNER'S	NAME (Fi	irst, Middle, Maiden				
BE (Bennie Blackwel	1				-	a Hunte				
2	19e. INFORMANT'S NAME (Type/Print)	7.7					Number, City or Town			146	
	Donald E. Blacky 200. METHOD OF DISPOSITION						uitland				
	1 Suriel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)	of from State cametery			Cemete	ry2,	73 ROC	ckvil	le,	MD	
	22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
	23. PART i. Enter the diseases, or cen ahock, or heart failure. Lis	nplications that caused the	death. Do n	ot enter the m	ode of dying, a	uch as	cardiac or respi	ratory arre	at,	Approximata Interval Between	
	IMMEDIATE CAUSE (Final disease or condition resulting in death) ### Carty intertinal Cleding DUE TO (OR AS A COMERCULENCE OF).										
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										
PHYSICIAN: MEDICAL	PART II. Other significant conditions of	ontributing to death but no	ot resulting is	the underlyin	g cause given	In Part I	24s, WAS AN PERFOR	MED?	AM CC OF	RE AUTOPSY FINDINGS ALLABLE PRIOR TO IMPLETION OF CAUSE F DEATH? YES 2 NO	
ž.	DID TOBACCO USE CONTRIE	SUTE TO CAUSE OF D	EATH YES	NO [UNCERT	AIN [1				
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:		OTHER:							
IYSI	1 VES 2 PNO 1	Inpatient 2 ER/Outpatient	3 🗆 DOA	4 - Nursing Non	ne 5 🗆 Reelden	_					
ву Р	1 Natural 5 Pending	28e. OATE OF INJURY (Month, Day, Year)	28b. TIME	RY W	JURY AT ORK? YES 2 NO	28d.	DESCRIBE NOW IN	IJURY OCCU	RED		
	2 Accident investigation 3 Suicide 8 Could not be determined	28s. PLACE OF INJURY — At building, etc. (Specify)	t home, ferm, at	raat, factory, offic	•	281, 1	LOCATION (Street e City or Town, State)	nd Number o	Rural Rout	e Number,	
COMPLETED		N: To the best of my knowledge,								nd menner as stated.	
H	296. SIGNATURE AND THE OF CENTURAL	ya			29c. LICENSE I	UMBER	37	29d. DATE :	SIGNED (M	onth, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO E	ALUJA MD	1TEM 27) (Type,	OW.	Mount	- Ri	MAI A	H, 1	Balt	to 21217	
	FEB 03 1995	32. REGISTRAR'S SIGNATURE					/				



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event,	
ed, or item 23 shows any injury, or other traumatic event, th	PHYSICIAN: MEDICAL CERTIFICATION
other	TIFIC
0	H
injury,	AL CE
ашу	
shows	: ME
23	Z
Item	Sic
0	7.8
8	H

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. I	Ю.	
	1. DECEDENT'S NAME (First, Middle, Lest) BERTRAM	MILTON		TOHNS	2/	2. DATE OF DEATH	DAY	YEAR 3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	20 17	
	081-07-0509		83 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year DEC.31	,1911	8. BIRTHPLACE (State or Foreign Country) NEW YORK
	9a. FACILITY NAME (If not institution, give si	treet and number)		9b. CITY, TOWN	OR LOCATION OF D			UNTY OF DEATH
DIRECTOR	SHADY GROVE	ADVENTIST	HOSP'T	ROCK	VILLE		MC	ONTGOMERY
ñ	10a. STATE 10b. COUNTY	1	10c, CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY
		NTGOMERY			HERSBUR	:G		LIMITS?
FUNERAL	106. STREET AND NUMBER 9610 BRAS	SIE WAY		10	7. ZIP CODE 20879		10g. CI	U.S.A.
3	11. MARITAL STATUS		N U.S. ARMED	13 WAS DE		NIC ORIGIN? (Specify	Yes or No	
	1 Never Married 2 Married	12. WAS DECEDENT EVER II FORCES? 1 X YES IF YES, GIVE WAR OR D.	2 NO	If yes, s	pecify Cuban, Maxica	III, Puarto Rican, etc.)	104 07 140-	14. RACE — American Indian, Black, White, etc.
Э ВҮ	3 Widowed 4 Divorced	WWII			S 2 X NO Specif	y:		Specify: WHITE
핕	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S (Give kind of	USUAL OCCUPAT work done during m se retired.)	ON ost of working	16b. KIND OF	BUSINESS/IN	IDUSTRY
ا۳	Elementary/Secondary (0-12)	College (1-4 or 5+)						
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		CREDI	T MANA		GEN		MOTORS CORP.
BE C	HARRY O	. JOHNSON	N		AN			IITH
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street		Route Number, City or	lown, State, Z	lp Code)
2		GAN	4005					. 22032
	20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Rame	20b	PLACE AND DATE	OF DISPOSITION /A	ame of	DATE 20c.		- City or Town, Stata
	4 Donation 5 Other (Specify)	CI	HAMBERS	CREMA	TORY	$1/31 \mid 1$	RIVER	RDALE, MD.
	21. SIGNATURE OF FUNERAL SERVICE LIC	amber A	240000		ND ADDRESS OF FA	S:	LVER	SPRING, MD.
	23. PART I. Enter the diseases, or o	complications that source				ERS CO.		
	ahock, or heart feilure.	Liel only one ceuse on e	ech iine.	iot enter the m	ode or dying, auc	n ss cardiec or re	apiratory ai	rrest, Approximate interval Between
,	IMMEDIATE CAUSE (Fine)	L . /	. 4 7		011	1000	-)-	Onset and Death
J	reaulting in death)	B. DUE TO (OR AS	CONSEQUENCE OF	nmou	CVDIVIL	1	4501	e smin
Z		POSSIL	ple n	mo ca	rdid in	Lerction Learning	n	1-2 days
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	701	11			11.
걸	CAUSE (Disease or injury	. Cong	CONSEQUENCE OF	Var	-101/V	ive.		Thios
Ē	that initiated events resulting in death) LAST	DOE TO (OH AS)A	CONSEQUENCE OF	r):	1			
Ü		š						
	PART II. Other algnificant condition	s contributing to death b	ut not resulting	In the underlylr	g ceuse given in	Part I. 24s. WAS	AN AUTOPSY	
EDICAL	Hyperte	nsion					2 NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE
ME	Prostati	e Cancer					- 4	DF DEATH?
	DID TOBACCO USÉ CONTR			S INO	UNCERTAIL	NO		
¥.	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT	FH (Check only one,				
S	1 TES 2 NO	HOSPITAL:	entlent 3 🗆 DOA	OTHER: 4 Nursing Hor	ne 5 🗆 Residence	6 Other (Specify)		
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	26b. TIM		JURY AT	28d. DESCRIBE HO	V INJURY OC	CURED
BY	1 Natural 5 Pending Investigation				YES 2 NO			
	3 Suicide 6 Could not be	26a. PLACE OF INJURY building, atc. (Spec	— At home, farm, a	atreet, factory, offic	ea .	261. LOCATION (Stre City or Town, Str		or Rural Route Number,
COMPLETED	4 Homicide determined					only or lown, on		
립	29a. CERTIFIER CERTIFYING PHYSIC	CIAN: To the best of my know	ledge, death occurre	ed at the time, dat	and place, and due	to the cause(s) end :	nenner as ata	nted.
0	one) 2 MEDICAL EXAMINE	R: On the basis of exemination	n and/or investigatio	n, In my opinion,	death occured at the	time, data and place,	and due to t	the cause(s) and manner as stated.
	296. SIGNATURE AND TITLE OF CERTIFIER	6 (29c. LICENSE NUI	WBER	29d. DA	TE SIGNED (Month, Day, Year)
D BE	Mordon	9 orde 1	7.D.		D 343	373		
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Club	House 6	214/1	· / · 1	nersbuy MD
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIGN	ATURE	LIUB	IJUNSCI	14 461)	OAIT	nersbury M()
	JAN 31 1995	Julia Davelson	Rardall					

4+1

S For a Contract of the Assert Annal Contract of the Contract 7 I

POOCHIKIAN

34: DATE FILED (Month, Day, War)

FEB 01 1995

32. REGISTRAR'S SIGNATURE
Julia Davelson hardall

/	Amended #/ FOR 1 - STATE REGISTRAR	2/1 /95 FATE OF MARY	YLAND /	nRT DEPAR	TMENT	MO OF HEAL OF DE	TH AND	Om o MENTAL	L HYGIENI	C0	5 un	94711
	1. DECEDENT'S NAME (First, Middle, Last)	ine			OAIL	OI DE	AIII	2. DATE	OF DEATH		3	. TIME OF DEATH
	MADELINE	G	JONES	:				MONTE	f DAY		YEAR	1:25 P M
	4. SOCIAL SECURITY NUMBER 5. SE	EX 6. AC	E (In yrs. lest		IF UNDER t	YEAR IF U	NDER 24 HRS	. 7. DATE	OF BIRTH		O. BIRTHPL	ACE (State or Foreign
	577-42-5239	M 2 ∑ F	92	YRS.	MONTHS	DAYS HOU	RS MIN.		25, 1		Country)	
	9a. FACILITY NAME (If not institution, give street an	id number)			9b. CITY, 1	OWN OR LO	CATION OF		22, 1		New TY OF DEA	
22	Prince George's Hosp	ital Cen	ter			verly						eorge's
DIRECTOR	RESIDENCE OF DECEDENT				Olic	verry				LLL	ice G	eorge s
W.	10e. STATE 10b. COUNTY			t0c. CIT	Y, TOWN OR	LOCATION					1	Od. INSIDE CITY
	MD Prince G	eorge's			Che	verly					1	YES 2 NO
FUNERAL	10e. STREET AND NUMBER					101. ZIP (CODE			10g. CITIZ	EN OF WH	AT COUNTRY?
i iii	6021 Hawthorne Stre	et					2	20785		U.	S. A	•
5		WAS DECEDENT EVER	R IN U.S. ARI	MED	13. W	S DECENDE	NT OF HISE	ANIC ORIGIN	? (Specify Yes	or No-	14. RACE	- American Indian,
BY	t Never Married 2 Married IF	YES, GIVE WAR OF	DATES	i O		YES 2		ican, Puerto F icity:	Rican, etc.)		Specify:	White, atc.
												White
TED	15. DECEDENT'S EDUCATION (Specify only highest grade comple	Hed)	(Gh	ve kind of v	USUAL OCC	UPATION ing most of w	rorking		KIND OF BUS			
2		ege (1-4 or 5 +)		Do NOT us					J. S. I			
COMPLET	12		Fina	ncia	1 Cle	200			Represe		ives	
	17. FATHER'S NAME (First, Middle, Last) William Greene					100			Aiddle, Maiden S	Sumame)		
H						E	Bridg	et Do	olan			
5	19e. INFORMANT'S NAME (Type/Print)							al Route Numb	er, City or Town	, State, Zip	Code)	
	Dorothy A. Shields		[60)21 H	lawtho	rne S	t. (Chever	ly, MI	20	785	
	20s. METHOD OF DISPOSITION 1X Buriel 2 Cremation 3 Removal for	om Stata	10b. PLACE A	ND DATE O	Pher place	ON (Name of		DATE		ATION - C	-	
	4 Donation 5 Other (Specify)		Gametery, crem Gate o	f He	aven	Cemet	ery	1/3	l Silv	er Sp	ring	MD
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	//-)		22. N/	ME AND ADI	DRESS OF	FACILITY	Joseph	Gaw1	er's	Sons
	* / xxxx 1 91 9	uno			5130) WI A	lve.	NW Wa	ashing	ton,	D.C.	20016
	23. PART i. Enter the diseases, or compli	cations that caus	ed the det	ath. Do n	ot antar th	a moda of	dying, at	uch aa card	lac or reapir	atory arre	et,	Approximate
	ahock, or heart failure. List or IMMEDIATE CAUSE (Final	nly one cause on	aach lina.							340, 344		Intarval Between Onset and Death
	disease or condition	echonol.	. Fo	. /.	2	e /	A	2RAC	-10	2		Consect and Double
	resulting in death) a. 1	DUE TO (OR A)	A CONSEO	UENCE OF	7):			1402	1/10	MI	u	
z	.	Cendi	,									İ
은	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS	S A CONSEO	UENCE OF	7:							1
ERTIFICATION	cause. Enter UNDERLYING	1618-	FI	B	Tees	en						
트	CAUSE (Disease or injury that initiated events	OUE TO (OR AS	A CONSEQ			1.	,					
E	resulting in death) LAST	Foots	zea/	-60	5/10	, fe	1110	atren	_			
Ö	PART II. Other algorificant conditions conf	tributing to death	but not a								_	
MEDICAL	TASS II. Ottar algrinicate conditiona con-	inbuting to death	DUT NOT NE	eaulting i	n tha und	rlying caus	se given i	in Part I.	24a. WAS AN A PERFORM		A	ERE AUTOPSY FINDINGS MILABLE PRIOR TO
ă									1 [] YES 2	□ NO		OMPLETION OF CAUSE F DEATH?
E											1	YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRIBUT	TE TO CAUSE					NCERTA	NN 🗆				
3	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	SPLFAL:	26. PLACE	OF DEAT	H (Check onl	y one)						
YS.	1 TES 2/ NO	npatient 2 - ER/O	utpatient 3	□ DOA	OTHER:	Home 5	Rasidence	a 6 🗆 Other	(Specify)			
표		28a. DATE OF INJUR (Month, Day, Year		28b. TIMI INJ	E OF 20	c. INJURY A'	т	28d. DE\$	CRIBE HOW IN	JURY OCC	JRED	
B	Netural 5 Pending 2 Accident Investigation				44	1 YES	2 NO					
1		28e. PLACE OF INJU building, atc. (S)	RY — At hon pecify)	ne, farm, a	treet, factory	offica			ATION (Street ar	d Number o	r Rural Rou	te Number,
E	4 Homicide determined											
7	29a. CERTIFIER Check only	the best of my kn	owledge, des	th occurre	d at the time	, data and pi	lace, and d	ue to the cau	ee(s) and manr	or as state	d.	
COMPLETED	one) 2 MEDICAL EXAMINER: On to											nd menner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER	$\overline{}$		-			LICENSE N					onth, Day, Year)
BE	wood	100CH	KIA	V,V	ICKE	= /			1			1-95
2	36. NAME AND ADDRESS OF PERSON WHO COM	PLETED CAUSE OF	DEATH (ITEM	27) (Type.	Print)		03472			- (-0	
/	PR. N. POOCHIKIAN 5	632 ANNA	POLIS	ROA	D, BL	ADENSE	BURG,	MARY	LAND			

FOR

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

* REGISTRAR			С	ERTIFIC	CATE	OF DEATH		REG. NO.				
1. DECEDENT'S NAME (First	t, Middle, Last)							OF DEATH			3. TIME OF DEAT	'H
	Vi	ctor Car	1	Jacob	son		Jani		Ö, 1	995	5:15	Рм
4. SOCIAL SECURITY NUM	BER !	5. SEX 6.	AGE (In yrs. la	at birthday)	IF UNDER 1 Y	EAR IF UNDER 24 HRS.	7. DATE	OF BIRTH	, 1	8. BIRTH	IPLACE (State or Fo	
298-09-6177	,	1 🔲 M 2 🗍 F	90	YRS.	WONTHS D	AYS HOURS MIN.		, Day, Year)	0/	Country	York	
9a. FACILITY NAME (If not in	nstitution, give stree	at and number)	90		Sh CITY TO	WN OR LOCATION OF I		15,19		INEW		
							ZEATH		9c. COL	INTY OF D	EATH	
3401 Fernda	<u>le Stree</u>	et			Ken	sington			M	ontgo	omery	
10e. STATE	10b. COUNTY			10c. CITY,	TOWN OR L	OCATION					10d. INSIDE CITY	
T71	7									- 1	LIMITS?	
Florida	Pasco			New	Port	Richey					1 YES 2 X	NO
						10f. ZIP CODE			10g. CI1	IZEN OF W	VNAT COUNTRY?	
3955 Lighth						34652				U.S.	Α.	
11. MARITAL STATUS		12. WAS DECEDENT EV FORCES? 1	YES 2	RMED NO	13. WAS	DECENDENT OF HISP/ is, specify Cuben, Mexic	NIC ORIGIN	? (Specify Yee	or No-	14. RACE	- American India	in,
1 Never Merried 2 3 Wildowed 4 Divo		IF YES, GIVE WAR				YES 2 NO Spec		ncen, etc.)		Specif		
					1					Wh	nite	
15. DEC (Specify oni	EDENT'S EDUCAT by highest grade co.	FION mpleted)		ECEDENT'S U		PATION ng most of working	16b.	KIND OF BUS	INESS/IN	DUSTRY		
Elementary/Secondary (T	College (1-4 or 5+)	ilii	. Do NOT use	retired.)	ng most or working						
12			Dra	ıftsma	n		He	ating	/Eng	ineer	ring	
17. FATHER'S NAME (First, M	fiddle, Last)					1S. MOTHER'S N						
John Jacob	SOT						na Be					
190. INFORMANT'S NAME (16	b MAII INC A	DDDESC (C)	reet and Number or Rura						_
Margaret L.											1 20005	
200. METHOD OF DISPOSIT		<u>cy</u>				le Street						
1 🔀 Buriel 2 🗌 Cremetic	on 3 A Remove	il from State	cemetery, cri	AND DATE OF	DISPOSITIO er place)		DATE		CATION -	City or To	wn, State	
4 Donation S Other				Park	Cemet		2/4/95	You	ngst	own,	Ohio	
21. SIGNATURE OF FUNERA	L SERVICE LICEN	SEE				ME AND ADDRESS OF F		-	4		_	
Rtunat	1/11/29	Can	411			ncis J. Co						
23 PART I Enter the d	1000	. Curpi			1 500	Universit	y Blv	rd.,W.	Sil	.Spr.		_
23. PART I. Enter the d ahock, or h	eert fellure. Lis	st Dnly one ceuee o	on each line	eeth. Do no e.	t enter the	mode of dying, au	ch ea cerd	iac or respi	ratory ar	rest,	Approxima	
IMMEDIATE CAUSE (FIR											Onset and	
disease or condition resulting in death)	→ .	Pneumonia	a								2 Day	S
to senting in occarry		DUE TO (OR	AS A CONSE	OUENCE OF):	:						- L Duy	
		Widesprea	ad met	astis	es						Yea	rs
Sequentially list condit		DUE TO (OR	AS A CONSE	OUENCE OF):							-	
cause. Enter UNDERLY	ING	Carcinoma	a of r	rosta	tο						V	
CAUSE (Disease or Inju- that initiated events	iry a.			OUENCE OF:							Yea	rs_
resulting in death) LAS	ar 📗			,							i	
	d										1	
PART II. Other significe												
	nt conditions	contributing to dea	th but not	reculting in	the under	lying cause given in	Part I.	24a, WAS AN	AUTOPSY	24b.	WERE AUTOPSY FII	NDINGS
	ent conditions	contributing to dea	th but not	reeulting in	the under	lylng ceuse given le	Part I.	PERFOR	MED?	24b.	WERE AUTOPSY FIL AMAILABLE PRIOR 1	ro
	ent conditions	contributing to dea	th but not	reculting in	the under	lying ceuse given in	Part I.		MED?	24b.		ro
							_	PERFOR	MED?	24b.	AVAILABLE PRIOR 1	NO AUSE
DID TOBACCO U	SE CONTRIE						_	PERFOR	MED?	24b.	AVAILABLE PRIOR 1 COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLE	NO AUSE
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	SE CONTRIE		E OF DEA	ATH YES	(Check only	UNCERTA	N 🗆	PERFOR	MED?	24b.	AVAILABLE PRIOR 1 COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLE	NO AUSE
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DIVISION OF VITAL RECORDS, P.O. BOX 68769

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit is be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

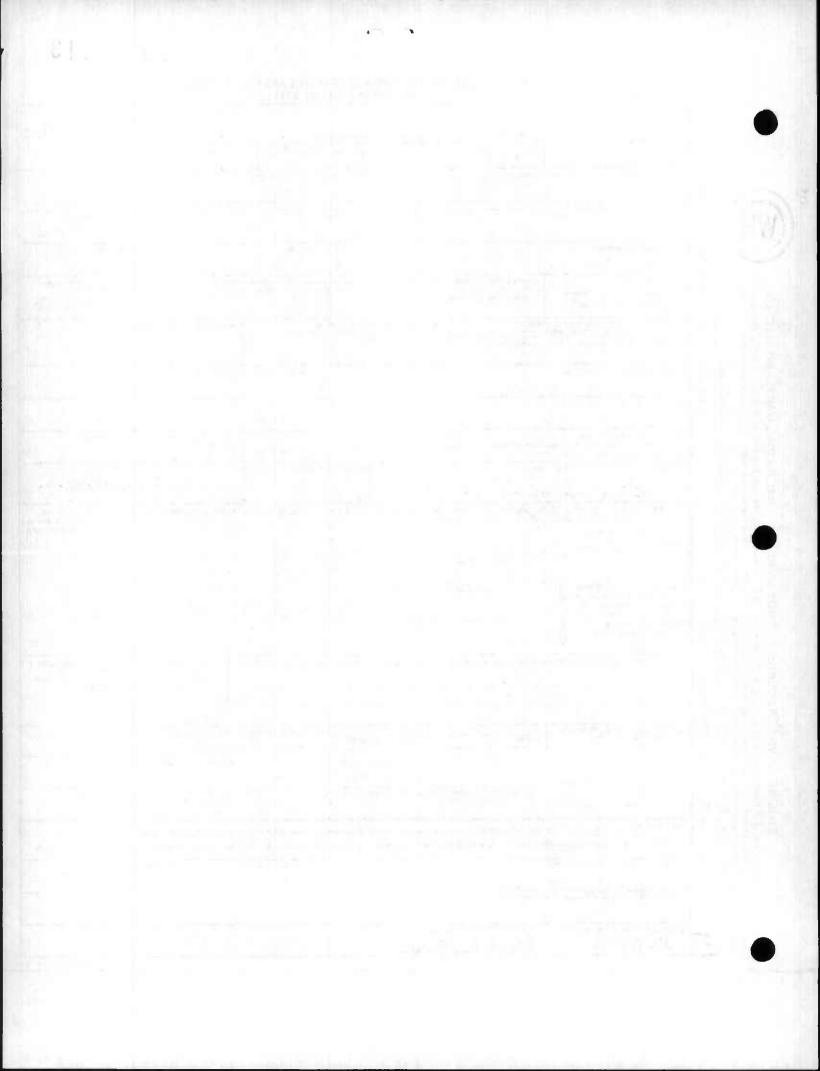
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DHMH-1S Rev 1/89

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY

1. DECEDENT'S NAME (First, Middle, Las	i)								OF DEATH	AY		3. TIME OF DEATH	
Olive	7\	V	ina					MONTH		1995	YEAR	10:50 P.	
4. SOCIAL SECURITY NUMBER	6. AGE (In yrs. In:					Jan.		1995		PLACE (State or Foreign			
4. SOURE SECONITY NOMBEN	5. SEX	6. AGE (III yrs. III		MONTHS	DAYS	HOURS	MIN.		Day, Year)		Country,	PLACE (State or Foreign	
215 36 0000	1 🗆 M 2 📈	90	YRS.					Foh	25.1	901	Mai	ryland	
9a. FACILITY NAME (If not institution, give	e street and number)	30		9b, CITY,	TOWN O	R LOCATI				9c. COUN	TY OF DE	ATH	
Pats Domiciliary					9b. CITY, TOWN OR LOCATION OF DEATH Sudlersville 9c. COUNTY OF DEATH Queen Anne's						Anne's		
M	-					2							
	RESIDENCE OF DECEDENT												
10a. STATE 10b. COUN	VTY			Y, TOWN OF		ION						10d. INSIDE CITY LIMITS?	
Wants land Vant				rtor	1							1 YES 2 NO	
Maryland Kent W					104	ZIP COD				10g. CITIZEN OF WHAT COUNTR			
12102 Still	تہ	21678					ING. CITIZEN OF WHAT COUNTY						
12102 Still	a	210/0					U.S.A.						
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AR								NIC ORIGIN	(Specify Yes	or No-	14. RACE	- American Indian, White, etc.	
1 Never Married 2 Married	FORCES? 1 IF YES, GIVE W	YES 2	119					in, Puerto F	Ican, etc.)				
3⊱ Widowed 4 □ Divorced	IF TES, GIVE W	AR UN DATES		,	☐ YES	Ž∏ NO	Specin	у:			Specify	Specify: White	
15. DECEDENT'S Et (Specify only highest gra	DUCATION ide completed!	16a, DI	ECEDENT'S	USUAL OC	CUPATIO	N et of workin	17	16b.	KIND OF BU	SINESS/IND	USTRY		
Elementary/Secondary (0-12)	College (1-4 or 5 +	life	Give kind of v e. Do NOT us	e retired.)	ornig mod								
11	2 1		mema	ker									
	£ 2	LIIO	mema	ILC I	-			44T 45					
17. FATHER'S NAME (First, Middle, Last)									liddle, Maiden				
John Wesley At	ttwell					M	ary	Zel	da C	olem	an		
19a. INFORMANT'S NAME (Type/Print)		10	Db. MAII ING	ADDRESS	(Street or		- 4		er, City or Tow				
												e. 19701	
Mrs. Jean K. I	Booth		100	Java	111110		T T A	- , vi	CDC,	Ded	T, DE	. 19/0	
20a. METHOD OF DISPOSITION			ANDDATE		TION /Nar	me of		DATE	20c. LO	CATION -	City or Tow	vn, State	
4 Burial 2 Cremetion 3 Re 4 Donation 6 Other (Specify)	emoval from State	cemetery, cre	rematory or of	ther place)			Jan	.4.1	995				
21. SIGNATURE OF FUNERAL SERVICE		Che	ster	Cen	ete	ry			C	hest	erto	own, Md	
21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	1.				D ADDRE	SS OF FA	CILITY					
1. 1/0/	01/1/	Vino		TC	om H	leli	enb	ein	Fune	ral	Home	es, P.A.	
Huk 7.	yjegen	perio		113	30 5	Spee	r R	d.,	Ches	tert	own,	, Md.216	
resulting in death)	DUE TO												
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	ove for	OR AS A CONSE	COVENCE OF	ק :				aj)					
Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	c. AS	OR AS A CONSE	EQUENCE OF	F):									
Sequentisily list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	c. AS	OR AS A CONSE	EQUENCE OF	F):		csuse (given in	Part I.	24s. WAS AN				
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BALTIMORE, MARYLAND 21215-0020	s after death. Page 6 may be retained by the hospital or attending physician	 by the funeral director, page 5 should be detached for use as the burial-tra emoval. 	dical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within at hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transfer be filed within 72 hours after death with the State Dept. of Health and Mental Aygiene prior to buriat, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILEO (Month, Day, Year)

32 REGISTRAR'S SIGNATURE
Julia Davidson Randall

	FOR STATE REGISTRAR	STATE OF M	MARYLAND /		TMENT				MENT	AL HYGIEN	_		
1	1. DECEDENT'S NAME (First, Middle, Last)				2. D.					E OF OEATH			3. TIME OF DEATH
	Pauline Marie				Kin	a			MON		AV P	YEAR	0155 H
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. last birthday)		IF UNDER	1 YEAR IF UNDER 24 HRS.			DATE OF BIRTH			8. BIRTHE	PLACE (State or Foreign
	216-14-2334 9a. FACILITY NAME (If not institution, give st	1 M 2 XF	90	YRS.				05-04-1904 Count			Country	dD	
BIBERTOR				ER	9b. CITY, TOWN OR LOCATION OF GEATH R SALISBURY Sec. COUNTY 6 WICOI					COMIC			
13	10a. STATE 10b. COUNTY			10c. CIT	9c. CITY, TOWN OR LOCATION 10d. INSI						10d. INSIDE CITY		
				Pocomoke City							LIMITS?		
FUNERAL	32162 Overhol					101	218				10g. CITIZEN OF WHAT COUNTRY? U.S.		
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED						ilN? (Specify Yes	or No-	14. RACE	— American Indian, While, alc.
B	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE Y	YES 2 N	Ю				in, Maxicar Specify		o Rican, etc.)		Specify	
	15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	16a. DE	CEDENT'S	USUAL OC	CUPATIO	N et of worki		-10	86. KIND OF BU	SINESS/INC	DUSTRY	
COMPLETED	Elementary/Secondary (0-12) 10th	College (1-4 or 5	-)	abo	work done of se retired.)	uning mo	SI DI WOFKI	19		Dom	estic		
8	17. FATHER'S NAME (First, Middle, Last)					_	16 MOT	MED'S NA	AE /Eleut	, Middle, Maiden	Pursana)		
	Monroe King							nie			Sumame)		
H	19a. INFORMANT'S NAME (Type/Print)	-	194	MAILING	ADDRESS	/Street a				mber, City or Tow	- Chata 7/a	Code	-
2	Lillian School	lfie1d								.1a. P		1915	51
	20a, METHOD OF DISPOSITION	-	20b. PLACE A			_			-			City or Tow	
	1 Depurise 2 Cremation 3 Ramoval from State Commetery, Grematory or other place Christ M.E. Cemetery 02-06-95 Rehobeth, MD												
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEC	Oni I	30 1.	22.1	NAME AN	D ADDRE	SS OF FAC	JUTY	d Fun		TTan	01050
	Al. Il	5 11	King										
	23 PART I Enter the diseases or o	emplications the	t coursed the de	oth Do									Anne, MD
	23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, ahock, or head failure. List only one cause on each line. Approximate Interval Between												
	IMMEDIATE CAUSE (Final disease or condition				14								Onset and Death
	disease or condition resulting in death) a. ONLIGHT (OR AS A CONSEQUENCE OR)								MUX				
_	s. OUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): OUE TO DR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	OUENCE OF):											
SAT I	cause. Enter UNDERLYING		•										
Ē.	CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CONSEC	UENCE O	F):				_				
ᇤ	resulting in death) LAST												
CC	PART II. Other aignificant conditions	contributing to	death but not r	noultina.	in the un	darlular		uluan ta t	20-01	Ta		Lan	
	PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO								AWAILABLE PRIOR TO				
									_	1 TYES 2	□ NO		COMPLETION OF CAUSE DF DEATH?
PHYSICIAN: MEDICA	DID TOP ACCOUNT CONTR	IDLITE TO CA	LICE OF DEAT	TII \/		40 F	115.14						1 TYES 2 NO
AN	DID TOBACCO USE CONTR	IBUTE TO CA					UNC	ERTAIN	<u> </u>				
Ö	25. WAS CASE REFERRED TO MEDICAL EXAMINER? CONTROL CONT												
₹	1 TES 2 NO	1 Inpatient 2 I		28b. TIM	-	ing Home		sidenca		her (Specify)			
	1 Natural 5 Pending	(Month, D			URY	WO	RIC?	- NO	28d. D	EŞCRIBE HOW II	NJURY OC	CURED	
2 Accident Investigation 2 Accident Investigation 28a. PLACE OF INJURY — At home, farm, street, tectory, office 28t. LOCATION (Street and Number or Rural								A. M. A.					
밀	3 Suicide 6 Could not be 4 Homicide detarmined 28s. PLACE OF INJURY — At home, farm, street, tectory, office City or Town, State) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)								ate Number,				
COMPLET	29a. CERTIFIER 1 CERTIFYING PHYSIC	IAN; To the best of	my knowledge, de	ith occum	d at the ti	me, dete	and place	and due	to the o	augala) and m	Mar sa san	and .	
ME	(Check only one) 2 MEDICAL EXAMINER												and menner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER	-						ENSE NUM					
BE	Shull	em. W	MM					1668			290. DAT	E SIGNED	Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)												

SATISBURY, md

result on A. V.

1	•	FOR STATE REGISTRAR

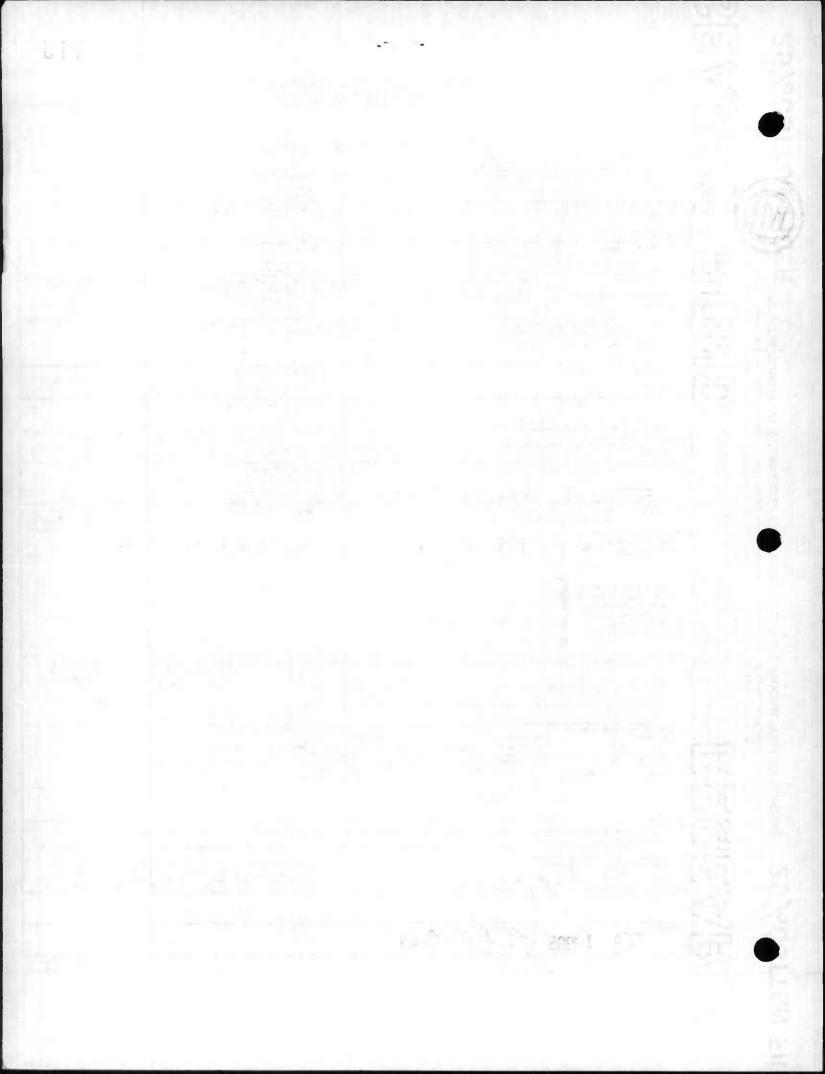
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CERTIF	ICATE O	F DEATH	REG. NO						
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DE.										
	ROSE KURST		FEB 2, 1995 YEAR 1:15 PM								
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthdey) YRS.	IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year) FEB 2, 1	910 1	BIRTHPLACE (State or Foreign Country) NEW JERSEY				
	Sa. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOW	N OR LOCATION OF D		9c. COUNTY					
DIRECTOR	205 QUAIL RUN DRIVE CENTREVILLE QUEEN										
E I	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION										
	MARYLAND QUEEN ANNE'S	ENTREV	/ILLE			1 YES 2 XNO					
FUNERAL	100. STREET AND NUMBER 205 QUAIL RUN DRIVE			101. ZIP CODE 21617			OF WHAT COUNTRY?				
	11. MARITAL STATUS 1 Never Merried 2 Married 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DO	2 NO	X NO If yes, specify Cuban, Mexican			, Puerto Rican, etc.) Blac					
Э ВУ	3 Wildowed 4 Divorced					Specify:					
TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S	work done during	TION most of working	16b. KIND OF BU	SINESS/INDUS	TRY				
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+)	He. Do NOT us	MAKER		O	NN HO	MIZ				
M	17. FATHER'S NAME (First, Middle, Last)	понь	MAKEK	10 MOTNED'S N	AME (First, Middle, Maiden		AE.				
Ö	JACOB MERK				ALENA GE						
BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Stra		Route Number, City or Tow		del				
2	FREDERICK L. KURST				EVILLE, I						
19	20a. METHOD OF DISPOSITION 20b	PLACE AND DATE	OF DISPOSITION	(Name of	DATE 20c, LO	CATION — CIN	y or Town, State				
	1 XBuriel 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify)	JR LADY	OF LO	URDES C	EM. 2-7	TRENT	ON, NJ				
	1 XBuriel 2 Cremation 3 Removel from State 4 Donation 6 Other (Specify) OUR LADY OF LOURDES CEM. 2-7 TRENTON, NJ 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY NEWNAM FUNERAL HOME, P.A.										
	JOHN R. MERCERON CFSP 200 S. HARRISON ST., EASTON, MD										
CERTIFICATION	anock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
	d	resulting in death) LAST									
MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FIND AMILIABLE PRIOR TO COMPLETION OF CAUSOF DEATH? 1 YES 2 NO										
AN	OF MAR CASE DEFENDED TO MEDICAL										
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	Supply of the same	OTHER:	PLACE OF DEATH (CI	neck only one)						
PHYSICIAN:	1 ☐ YES 2 NO 1 ☐ Inpetient 2 ☐ ER/Outp 27. MANNER OF DEATN 28s. DATE OF INJURY	28b. TIM	4 Nursing F	NJURY AT	6 ☐ Other (Specify) 28d, DESCRIBE NOW	NJURY OCCUR	RED				
ВУ Р	1 Secure 5 Pending (Month, Day, Year) 200. Time OF INJURY OCCURED WORK? Accident Investigation										
	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination										
TO BE C	29b. SIGNATURE AND TITLE OF CONTIFIER			29c. LICENSE NU	SH 8	294. DATE S	S A S				
	31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGN.	.09 S.		RCE ST.,	CENTREV	ILLE,	MD 21617				
	31. DATE FILED (Month, Day, Year) FEB - 3 1995 Falsa Divides	Kardall									

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a flow rater death. Page 6 may be retained by the law requires that the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filled within 72 hours after death with the State Dept, of Health and Mental Hygiens prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89



FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		C	ERTIF	ICATE C	F DEAT	ГН	F	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF MONTH			MEAD	3. TIME OF DEATH
	Boris S. Khanin							_	27. 1	1995	YEAR	м
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER 1 YE			T DATE OF	DISTRICT A		8. BIRTH	PLACE (State or Foreign
	214–31–1717	1 🔀 M 2 🗆 F	60	YRS.	MONTHS DA	8 HOURS	MIN.	May 1	9, 19	934	Country	Russia
	90. FACILITY NAME (If not institution, give s	street and number)			9b. CITY, TO	YN OR LOCATE	ON OF DE				INTY OF DE	
OR	4700 Bradley Blv	d. #311			Chevy	Chase				Mor	nygom	ery
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	v		I an or	Y, TOWN OR LO	0471041						
DIRECTOR		gomery		100, 011	Chevy							10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	gomery			Chevy	101. ZIP COD	-			40 000		1 X YES 2 □ NO
R.	4700 Bradley Blv	-d				20815				10g. CI1		HAT COUNTRY?
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	T EVER IN U.S. AL	BMED	12 WAS			IIC ORIGIN? (S	analth, Was	an Ma		sian
	1 Never Married 2 Merried		YES 2X		It yes	specify Cuba	n, Mexicer	n, Puerto Ricar	n, atc.)	or No-	Black	— American Indian, , White, atc.
Β¥	3 Widowed 4 Divorced	11 163, 0176 11	AN ON DATES		'''	TES 2 NO	Specify	r:			Specif	White
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade		16a. DE	ECEDENT'S	USUAL OCCUP work done during	ATION		16b. KIN	O OF BUS	SINESS/INI	DUSTRY	
<u></u>	Elementary/Secondary (0-12)	College (1-4 or 5 +	lide.	Do NOT u	se retired.)		·v					
A P		5+		Ar	chitect	;		Arcl	nited	cture	5	
8	17. FATHER'S NAME (First, Middle, Last)					18. MOTI	HER'S NAM	ME (First, Middl	le, Maiden	Sumame)		
띪	Samuel Khanin							Derka				
2	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (Str	et end Number	or Rural R	loute Number, (City or Yowi	n, State, Zij	p Code)	
	Irina Khanin				radley_		#311					
	1 ☐ Burlel 2 ☼ Cremation 3 ☐ Rem	oval from State	comotony on	amatan, or a	OF DISPOSITION ther place)	,		DATE			City or Tov	, 0.0.0
	4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	neses/)	Metr	.codo.	itan Cr	emator	Y 1	1-128	ALE	xanc	dria,	Va.
- 1	10 no	7/							Dir	rect i	ion	
	" Chel Dal	¥			1091	Rock	rille	Pike	Rock	vill	Le, M	d. 20852
	23. PART I. Enter the diseases, or a shock, or heart failure.	complications that List only one cause	coused the de	eath. Do i	not enter the	mode of dyl	ing, such	es cardisc	or reepl	retory an	reet,	Approximate interval Between
	The second secon	RECTA			+1	ma a d	4.4	+ 1.				Onset and Desth
	reculting in death)					1161	43/6	16 71				44295
		DUE TO	OR AS A CONSE	OUENCE O	F):							
CERTIFICATION	Sequentially list conditions,	b. DUE TO (OR AS A CONSE	OUENCE O	FI:							
¥	if any, leeding to immediate cause. Enter UNDERLYING			occupt &								İ
Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSE	OUENCE O	F):							-
ᇤ	reaulting in deeth) LAST	d,										
	PART II. Other significent condition	e contributing to	dooth but ant .		la dha a da d							
DICAL	The state of the s		deeth but not i	resulting	in the under	ying ceuse (jiven in i	PBFt I. 24a	PERFOR			WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
								t[YES 2	NO		OF DEATH?
Σ	DID TORACCO LICE CONT	DIDLITT TO CAL	ICE OF DEA	-						,		1 TYES 2 NO
AN	DID TOBACCO USE CONTI	KIBUTE TO CAL			TH (Check only o		ERTAIN	1 🗆				
PHYSICIAN: ME	EXAMINER?	HOSPITAL:			OTHER:			- 9	-			
Ĭ	27. MANNER OF DEATH	1 Inpatient 2 I		28b. TIM	4 Nursing I	INJURY AT	aldence (6 ☐ Other (Sp 28d. DESCRIE		HIIIRY OC	CHEED	
	1 Natural 5 Pending	(Month, Da		INJ	IURY	WORK7	NO	zoa. Dzgomi	DE HOW II	IJONT OC	CONED	
6	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF	INJURY — At ho	ome, term, s				281. LOCATIO	N (Street e	nd Number	r or Rural Ac	oute Number.
	4 Homicide determined	building, e	etc. (Specify)						wn, State)			
۳	290. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the heat of a	my knowledge de	eth occum	ad at the time	late and place	and due t	a Massa.	. e2.1 2 e		(i)	
COMPLET	(Check only one) 2 MEDICAL EXAMINE											and manner as stated
	29b. SIGNATURE AND TITUE OF CERTIFIER								prioce, ent			
8	LE ALL						8 7-			29d, DAT	1/22	(Month, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUS	E OF DEATH (ITE	M 27) (Type	. Print)						1.1	1 J
	/18/01 Pais	e Pholo	n d	DLA	ca M	ر هنه و	7 L	r. Art	hur	Scho	enac'	Ы
	31. PATE FILED (Month, Day, Year)	32. DEGISTRAP	S'S SIGNATURE		/			T + 17F	TIME	20110	cigo	LG
	31. DATE FILED (Month, Day, Year) JAN 31 1995	Julia do	water Re	dall								

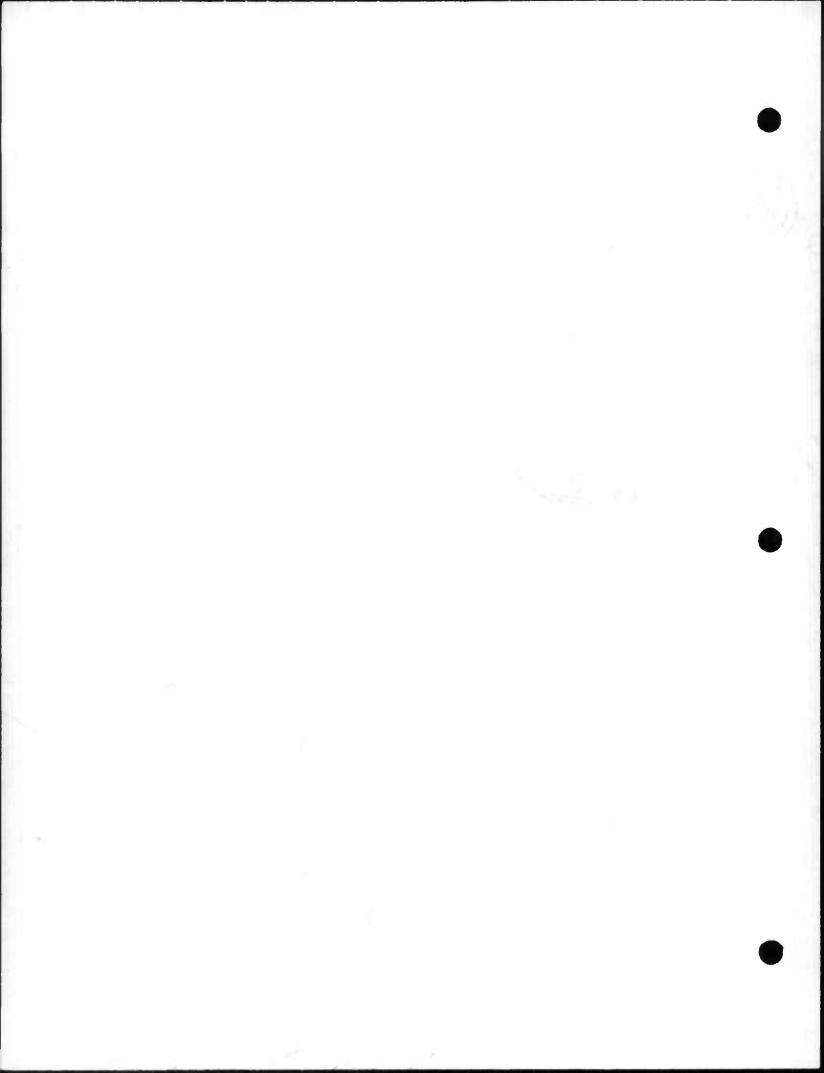
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit pe filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-18 Rev 1/89



BALTIMORE, MARYLAND 21215-002

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		28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at on
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	s after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or rem	60
	ftel	00
	- 60	2

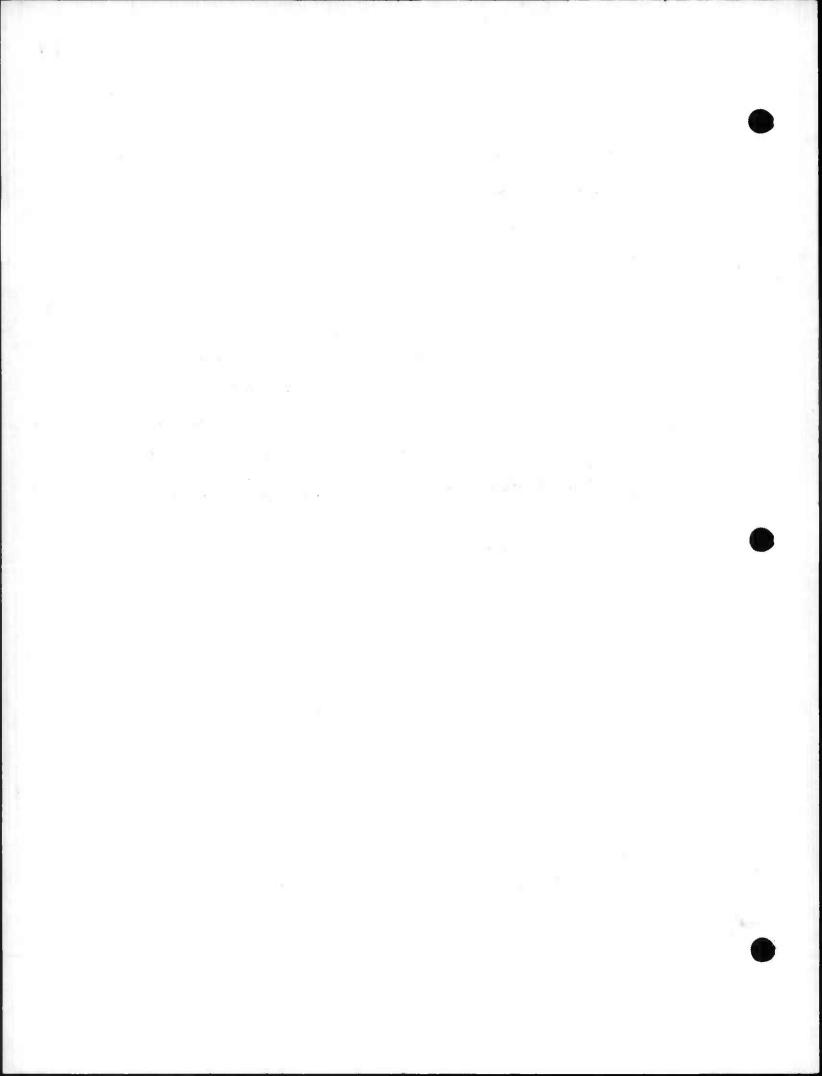
								95	04717			
	FOR 1 STATE	STATE OF MARYL					L HYGIENE					
	REGISTRAR		CERTIF	ICATE O	F DEATH		REG. NO.					
		KENDALL					OF DEATH MUARY 2	, 1995	3. TIME OF DEATH 8:15 PM			
	The second of the second		(in yrs. last birthday)	IF UNDER 1 YEAR		HRS. 7. DATE	OF BIRTH h, Day, Year)	11.1	BIRTHPLACE (State or Foreign Country)			
	298-09-8579 1 9s. FACILITY NAME (If not institution, give street		80 YRS.	OF CITY TOW	N OR LOCATION	Apri	1 24,1		ennsylvania			
DIRECTOR	Memorial Hospital δ		enter		erland			9c. COUNTY	legany			
- E	10s. STATE 10b. COUNTY			Y, TOWN OR LO					10d. INSIDE CITY LIMITS?			
	Maryland Allega	ny	Cu	mberlar	nd				1 TYES 2 NO			
FUNERAL	100. STREET AND NUMBER				10f. ZIP CODE	200			OF WHAT COUNTRY?			
N.	1/5 Sunset Drive	. WAS DECEDENT EVER IN	N U.S. ARMED	13. WAS I	2/5	UZ HISPANIC ORIGII	N7 (Specify Vee	USA	RACE — American Indian.			
	1 Never Married 2 Married	FORCES? 1 YES	2 JNO	If yes,		Mexican, Pusrlo		O NO - 14.	Black, Whits, stc.			
BY	3 🔀 Widowed 4 🗌 Divorced				~ ~				White			
TED	15. DECEDENT'S EDUCATI (Specify only highest grade com	npleted)	16a. DECEDENT'S (Give kind of v life. Do NOT us	vork done durina		168	, KIND OF BUS	INESS/INDUST	RY			
P.E.	Elementary/Secondary (0-12) C	College (1-4 or 5+)	Housew	ile			own ho	me.				
COMPLET	17. FATHER'S NAME (First, Middle, Last)				The state of the state of	R'S NAME (First,		Surname)				
BE	Morris Clifford Husted Ruth Hartzell											
2									de)			
200	20s. METHOD OF DISPOSITION	20b	DI ACE AND DATE	OF DISPOSITION	/Alama of	DAT	200 100	ATION CIN	or Town, Stats			
	1.X Buriel 2 Cremstion 3 Removal	from State #	Hillcrest Burial Park Feb 5, 1995 Cumberland, ND									
	21. BROWNELURE OF FUNERAC DERVICE LICENS	SEE	22. NAME AND ADDRESS OF FACILITY Hafer Chapel of the Hills Mortuary 1302 National Hwy, LaVale, ND 21502									
D. C. C.	1 Congress D	Hape		/302	Natio	nal Huu	ne nec	Le Mi	21502			
anica	23. PART I. Enter the diseases, or com shock, or heart fellure. List			not enter the	node of dying), auch aa car	diac or respir	alory arrest.	Approximete interval Between			
	IMMEDIATE CAUSE (Final disease or condition	0	f.i.	0					Onset and Death			
, ,	resulting in death) s	DUE TO (OR AS A	ONSEQUENCE OF	X	scorp		10 40					
		552 10 (611 26 2	CONSEGUENCE OF	,.					i '			
RTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (DR AS A	CONSEQUENCE OF	F):								
CA	CAUSE (Disease Dr Injury	DUE TO (OD 46 4	000000000000000000000000000000000000000	_								
H	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	F):								
CE	Ü											
MEDICAL C	PART II. Other significant conditions c	6 1	out not resulting	In the underly	ring cause giv	ren in Part I.	24a. WAS AN A PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
EDI	Consistive her	wit law	line				1 YES 2	Zwo	OF DEATH?			
		-	CAUSE OF	DEATH	YES []	NO IS			1 TYES 2 NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		CAROLE OF			TH (Check only o	ne)					
SIC		OSPITAL: Vinpetient 2 - ER/Outp	patient 3 DOA	OTHER: 4 Nursing H	ome 5 🗆 Resid	dencs 8 🗆 Oth	er (Specify)					
PH.	27. MANNER OF DEATH 1 Natural 5 Pending	26s. DATE OF INJURY (Month, Day, Year)	28b. TIM INJ	URY	INJURY AT WORK?		SCRIBE HOW IN	JURY OCCUR	ED			
BY	2 Accident Investigation	28e PLACE OF INJURY	- At home form		YES 2 1		CATION (Character	ad Alumbar as S	Sund Davids Mumber			
LED IS	Ш 4 ☐ Homicide determined											
COMPLET	29e. CERTIFIER Check only CERTIFYING PHYSICIAL	N: To the best of my know	riedge, death occurr	ed at the time. o	ats and place. a	nd due to the ca	use(s) end men	ner ss atated.				
O W	one)								puse(s) and manner es stated.			
il w l	29b. SIGNATURE AND TITLE OF CENTIFIER	-			29c. LICENS	SE NUMBER		29d, DATE SH	GNED (Month, Day, Year)			
0 8	1 sour				D 14	865		> 2	-4-55			
	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DE	ATH /ITEM 27\ /Time	Print1								

M.D. Memorial Hospital Medical bldg. Cumberland MD

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Day, Year) 1995

21502



TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1	-	FOR STATE REGISTRA	\.
, [1. D	ECEDENT'S	di

1. DECEDENT'S NAME (First, A							2. DATE	REG. NO	æ3,95		3. TIME OF DEATH
CARBLYN	-	ANE	CAROLYH	LA	NE		JANU	ARY	ws,93	95	10:45 M
4. SOCIAL SECURITY NUMBER	R	5. SEX	6. AGE (In yrs. In	st birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE (OF BIRTH Day, Year)		8. BIRTH Countr	IPLACE (State or Foreign
219-14-4748	;	1 □ M 2 ☑ F	80	YRS.	MONTHS DAYS	HOURS MIN.			1914		YLAND
9a. FACILITY NAME (If not insti	itution, give s	treet and number)			9b. CITY, TOWN	OR LOCATION OF D	EATH		9c, COU	INTY OF D	EATH
10th STRE					POCOL	MOKE			WC	RCES	TER
RESIDENCE OF DECE	10b. COUNTY			I son CIT	Y, TOWN OR LOCA	TION					10d. INSIDE CITY
				1		IION					LIMITS?
MARYLAND 100. STREET AND NUMBER	WOR	CESTER		<u> </u>	OCOMOKE	of, ZIP CODE	_		10a CIT	TIZEN OF Y	1 YES 2 NO
	OD DELL										WHAT COOKINT?
515 PITTS	CREEK		NT EVER IN U.S. A	MED		21853 CENDENT OF HISPA	NIC OBIGIN	2 (Specify Ve		ISA 14 BACI	E — American Indian,
1 Never Married 2 N	Aerried	FORCES?	YES 2 T	NO	If yes, s	pecify Cuban, Maxica	an, Puarto R		4 01 110—	Blaci	k, White, etc.
Widowed 4 Divorc	ped	IF YES, GIVE	WAR OR DATES		1 1 76	S 2 X NO Specif	ny:			Spec	**y:BLACK
	DENT'S EDU		16a. Di	CEDENT'S	USUAL OCCUPAT	ION	16b.	KIND OF BU	ISINESS/IN	DUSTRY	
(Specify only in Elementary/Secondary (0-1		College (1-4 or 6	- 16	. Do NOT u	work done during m se retired.)	lost or working					
7th			I	HOUSE	KEEPING	G		DOMES'	TIC		
17. FATHER'S NAME (First, Mid	idle, Last)					18. MOTHER'S NA	AME (First, A	fiddle, Maider	Surname)		LET ELETY
SOLOMON	CROPP	ER				GENI	EVA C	ROPPE	R		
19a. INFORMANT'S NAME (Typ	oe/Print)		19	b. MAILING	ADDRESS (Street	and Number or Rural	Route Numb	er, City or Tox	wn, State, Zi	ip Code)	
EMMA LEE	SCOFI	ELD		51	5 PITTS	CREEK LA	ANE,	POCOM	OKE,	MD.	21853
20a. METHOD OF DISPOSITIO		med deam State	20b. PLACE	OF DISPO	SITION (Name of co	emetery, crematory or		20c. L	CATION -	- City or To	own, State
Donation 6 🗆 Other (8		Oval Nom State			EDONIA (CEMETERY	JA	N. 28,	95	WES	TOVER, MD.
21. SIGNATURE OF FUNERAL	SERVICE LI	CENSEE				AND ADDRESS OF F		TINITED A		TT OF	
	3				D	ENNIE SMI .o. BOX 1					
disease or condition resulting in death) Sequentially list condition if any, leading to immed cause. Enter UNDERLYIM CAUSE (Disease or injur	ons, liats	b. CVA	O (OR AS A CONSE	OUENCE O							
	l		O (OR AS A CONSE		18						1 YA
resulting in death) LAST	-	DUE TO	O (OR AS A CONSE	OUENCE O	- T 1 A	ng ceuse given ir	n Part I.	24a. WAS A PERFC	RMED?	/ 241	1 41
	nt condition	d	O (OR AS A CONSE	OUENCE O	in the underlyle	ng ceuse given ir		PERFO	RMED?	244	b. WERE AUTOPSY FINDING AMBILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
PART II. Other significan	nt condition	d	O (OR AS A CONSE	resulting	In the underlying		theck only on	PERFO	RMED?	241	b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
PART II. Other significant in the significant in th	nt condition	d	O (OR AS A CONSE	resulting	28.1 OTHER: 4 Nursing Ho	PLACE OF DEATH (C	heck only or	PERFO	PRMED?		b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
PART II. Other significan 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 P	nt condition	d	O (OR AS A CONSE	resulting	28.1 OTHER: 4 Nursing Ho	PLACE OF DEATH (C	heck only or	PERFC 1 YES 1 (Specify)	PRMED?		b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
PART II, Other significant in the significant in th	o MEOICAL Pending neestigation Could not be	HOSPITAL: 1 Inpatient 2 28e. PLACE	O (OR AS A CONSE	resulting 3 □ DOA 20b. Till	OTHER: 4 Nursing Ho ME OF JURY M 1	PLACE OF DEATH (C	Sheck only on S Other 28d. DES	PERFC 1 VES 1 (Specify) SCRIBE HOW	PRMED? 2 (%/NO INJURY O	CCURED	b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
PART II. Other significan 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 P 2 Accident ir 3 Suicide 6 C 4 Homicide	nt condition MEOICAL Pending nestigation	HOSPITAL: 1 Inpatient 2 28e. PLACE	O (OR AS A CONSE	resulting 3 □ DOA 20b. Till	OTHER: 4 Nursing Ho ME OF JURY M 1	PLACE OF DEATH (C	Sheck only on S Other 28d. DES	PERFC 1 VES 1 (Specify) SCRIBE HOW	PRMED? 2 (%/NO INJURY O	CCURED	b. WERE AUTOPSY FINDING AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PART II. Other significant 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 MANO 27. MANNER OF DEATH 1 Netural 5 P 2 Accident if 3 Suicide 6 C 4 Homicide 20e. CERTIFIER (Check only)	D MEDICAL Pending resettjetton Could not be determined	HOSPITAL: 1 Inpetion 2 28e. DATE C (Month, 28e. PLACE building	D (OR AS A CONSE D death but not ER/Outpetient FINJURY Dey, Year) OF INJURY — At It g, atc. (Specify)	resulting 3 DOA 28b. Till IN	28. In the underlyle 28. In the underlyle 28. If A Nursing Ho ME OF 28c. If A Nursing Ho ME OF 1 Street, factory, off	PLACE OF DEATH (Come 6 & Residence NJURY AT YORK? YES 2 NO	28d. DES	PERFC 1 YES or (Specify) SCRIBE HOW ATHON (Streen or Town, State use(a) and m	PRMED? 2 (S/NO INJURY Or t and Numb p)	CCURED or or Rural stated.	D. WERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
PART II. Other significan 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 P 2 Accident Ir 3 Suicide 6 C 4 Hemicide 29a. CERTIFIER (Check only one) 2 MEDIC	D MEDICAL Pending meetigation Could not be betermined	d	D (OR AS A CONSE D death but not ER/Outpetient FINJURY Dey, Year) OF INJURY — At It g, atc. (Specify)	resulting 3 DOA 28b. Till IN	28. In the underlyle 28. In the underlyle 28. If A Nursing Ho ME OF 28c. If A Nursing Ho ME OF 1 Street, factory, off	PLACE OF DEATH (Come 8 Residence NJURY AT ORK? YES 2 NO lice te and place, and du, death occured et the	28d. DES 28f. LOC City as to the care time, data	PERFC 1 YES or (Specify) SCRIBE HOW ATHON (Streen or Town, State use(a) and m	PRMED? 2 SKNO INJURY Of tand Numbers enner as stand due to	CCURED or or Rural inted.	D. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Route Number,
PART II. Other significant 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 2 Accident if 3 Suicide 6 C C C C C C C C C C C C C C C C C C	D MEDICAL Pending meetigation Could not be betermined	d	D (OR AS A CONSE D death but not ER/Outpetient FINJURY Dey, Year) OF INJURY — At It g, atc. (Specify)	resulting 3 DOA 28b. Till IN	28. In the underlyle 28. In the underlyle 28. If A Nursing Ho ME OF 28c. If A Nursing Ho ME OF 1 Street, factory, off	PLACE OF DEATH (C	28d. DES 28f. LOC City 4s to the care time, deta	PERFC 1 YES or (Specify) SCRIBE HOW ATHON (Streen or Town, State use(a) and m	PRMED? 2 SCNO INJURY Of and Numbers as stand due to 29d. DA	ccured or Aural stated.	Acute Number, Route Number, (a) and menner as stated.
PART II. Other significan 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 P 2 Accident Ir 3 Suicide 6 C 4 Hemicide d	D MEDICAL Pending nvestigation Could not be letermined OF CERTIFIE	HOSPITAL: 1 Inpatient 2 28e. DATE C (Month, 28e. PLACE building	O (OR AS A CONSE	resulting 3 DOA 29b. TH IN ome, ferm,	28. In the underlyle 28. In the underlyle 28. If the Nursing Ho ME OF 28c. If the Nursing Ho Street, factory, off the time, design, in my opinion,	PLACE OF DEATH (Come 8 Residence NJURY AT ORK? YES 2 NO lice te and place, and du, death occured et the	28d. DES 28f. LOC City us to the cause time, data	PERFC 1 YES or (Specify) SCRIBE HOW ATHON (Streen or Town, State use(a) and m	INJURY Of tand Number of tand due to 29d. DJ	ccured or or Rurel lated.	D. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Route Number,





3. TIME OF DEATH

22:20 P

6. BIRTHPLACE (State or Foreign

MD.

10d. INSIDE CITY LIMITS?

14. RACE — American Indian, Black, White, etc.

1 X YES 2 NO

WHITE

Approximata

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

1 YES 2 NO

OF DEATH?

29d. DATE SIGNED (Month, Day, Year)

FEB.07,1995

111 Penn Street, Baltimore, Maryland 21201

Interval Between

Onset and Death

9c. COUNTY OF DEATH

USA

WORCHESTER

10g. CITIZEN OF WHAT COUNTRY?

Specify:

BERLIN, MD.

32. REGISTRAR'S SIGNATURE

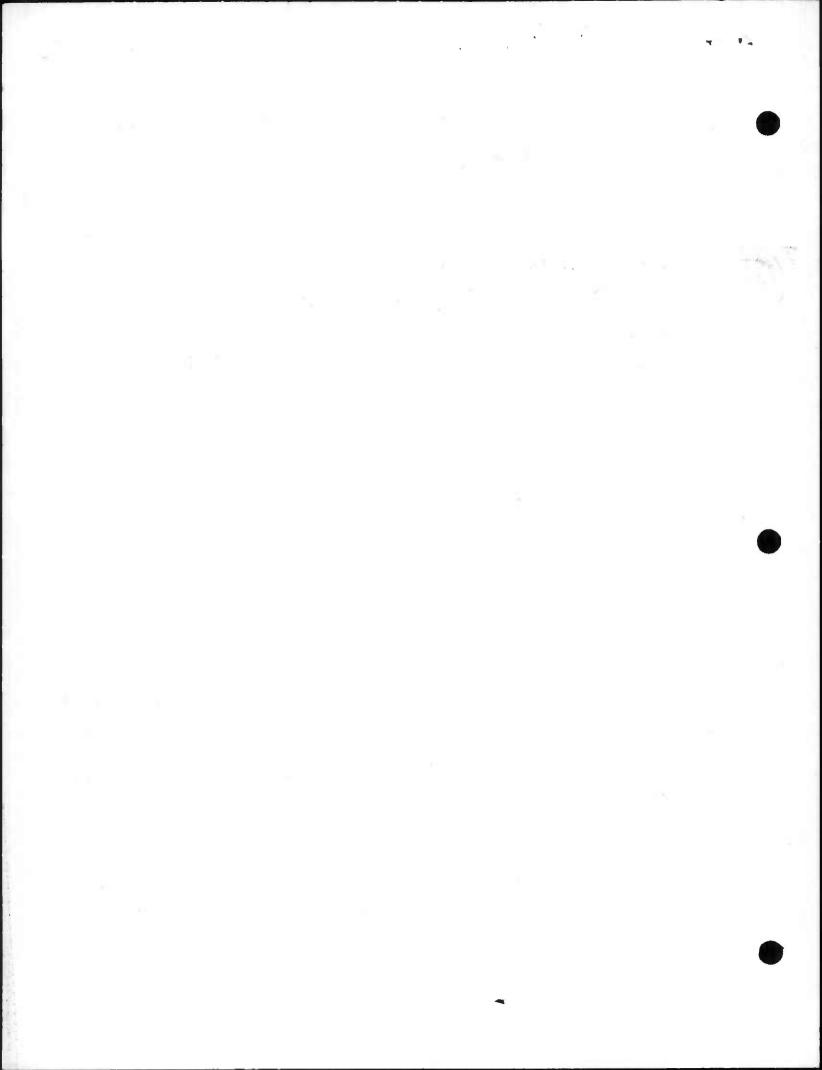
whi Dender Rudoll

31. DATE FILED (Month, Day, Year)

FEB 08 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DHMH-18 Rev 1/89



Amended # 196, 1/30/95

By For Talbot Co. STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1. STATE

1 - REGISTRAR		CERTIF	ICATE C	F DEATH		REG. NO.			
1. DECEOENT'S NAME (First, Middle, Last)						E OF DEATH			3. TIME OF OEATH
*	Roland	Winfield	Т	omax	Jan		6 199	YEAR	8:31 AM M
		E (In yrs. last birthday)			7. DAT	E OF BIRTH	0 19	8. BIRTH	IPLACE (State or Foreign
217-10-3658	M 2 □ F	83 YRS.	MONTHS DA	YS HOURS MIN.		nth, Day, Year) t 8, 19	111	Countr	aryland
9s. FACILITY NAME (If not institution, give street	t and number)	00	9b. CITY, TO	WN OR LOCATION OF		1 0, 10		INTY OF D	
									LAI!
Memorial Hospital	at Eastor	1	Easton				Tal	bot	
10s, STATE 10b, COUNTY		10c, CI1	Y, TOWN OR LO	DCATION					10d, INSIDE CITY LIMITS?
Maryland Talb	ot	St	. Mich	aels					1 XYES 2 NO
10e. STREET AND NUMBER				10f. ZIP COOE			10g. CIT	IZEN OF V	VHAT COUNTRY?
119 Grace	Street			21663			USA		
	2. WAS DECEDENT EVE	R IN U.S. ARMED	13. WAS	DECENDENT OF HISPA	ANIC ORIG	IN? (Specify Yes	or No-	14. RACE	- American Indian,
1 Never Married 2 Merried 3 Widowed 4 Ofvorced	FORCES? 1 Y	OATES 2 NO		i, specify Cubsn, Maxid YES 2 X NO Spec		Rican, etc.)		Speci	k, White, etc.
3 Widowed 4 Divorced				-					White
15. DECEDENT'S EDUCAT (Specify only highest grade co.	TON npleted)	16a. DECEDENT'S (Give kind of	work done during	PATION g most of working	10	Sb. KIND OF BUS	SINESS/INI	DUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT u	se retired.)						
8		Watern	nan			Seafood	1		
17. FATHER'S NAME (First, Middle, Lest)				16. MOTHER'S N	IAME (First	, Middle, Maiden	Surname)		
H. Bateman	Lomax			Est	her '	W. Harr	rison	1	
19a, INFORMANT'S NAME (Type/Print)		196. MAILING	ADDRESS (Str	eet and Number or Rura	l Route Nu	mber, City or Tow	n, State, Zij	o Code)	
Freda H. Lomax		119 (irace S	treet, 🕦	9	St. Mic	chae l	s, M	D. 21663
20s. METHOD OF DISPOSITION 1X Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State	20b. PLACEANO DATE cemetery, cremetory or o	OF DISPOSITION	N (Name of	OA	TE 20c. LO	CATION -	City or To	wn, State
		Spring Hi		eterv 1	/28/	95 Eas	ston,	Mar	yland
21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE	~ 0		E ANO ADDRESS OF F	ACILITY				
Haruson C	2 Los	nasd		rison E.					
23. PART i. Enter the diaeases, or con	plicationa that caus	sed tha death. Do	not anter the	S. Talbo	ch ee ce	rdiac or respi	Wilch	aels	MD. 21663
shock, or heart fellure. Lie	t only ona ceuse or	aech lina.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		raine or raspr	idioiy di	1001,	interval Between
iMMEDIATE CAUSE (Final disease or condition		T 6							Onset and Daath
reaulting in death)	Myocardial	Intarcti							minutes
			r):						
Sequentiany net conditione,	coronary c	ISEASE S A CONSEQUENCE O	E).						yrs.
if any, leading to immediate csuse. Enter UNDERLYING	(0.1.1.		. ,						
CAUSE (Disease or Injury c. that initisted evente	DUE TO (OR A	S A CONSEQUENCE O	Fi:						
resulting in death) LAST									İ
d									-
PART II. Other significant conditions of		but not reaulting	In the underl	ying cause given in	n Part i.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS
Recent Arrhythm	ias					1 YES 2			AVAILABLE PRIOR TO COMPLETION OF CAUSE
							ME		OF DEATH?
DID TOBACCO USE CONTRIB	UTE TO CAUSE	OF DEATH YE	S NO	☐ UNCERTA	IN 🗆				,
25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA							
	OSPITAL: Inpatient 2 ER/O	utpetient 3 🕅 DOA	OTHER:	Home 5 🗆 Residence	a \square on	ser (Snecify)			
27. MANNER OF DEATH	28s. DATE OF INJUR	Y 28b. TIM	E OF 28c.	INJURY AT	_	ESCRIBE HOW II	NJURY OC	CURED	
1 Natural 5 Pending	(Month, Day, Year) INJ	M 1	WORK? YES 2 NO					
2 Accident Investigation 3 Suicide Could not be	28s. PLACE OF INJU	RY — At home, farm,	street, factory, o	office	281, LO	CATION (Street a	and Number	or Russ B	huite Mumber
4 Homicide 8 Could not be	building, stc. (S	pecify)	, , , , , , ,		Cit	y or Town, State)	no mamba	Or Fighting 11	outo Number,
29a. CERTIFIER	- 40 - 10 - 10 - 10 - 10 - 10 - 10 - 10				1		w-00		
(Check only one) 2 CERTIFYING PHYSICIA									
2 MEDICAL EXAMINER: (on the basis of examina	tion and/or investigation	n, in my opinio	n, death occured at th	e time, da	is and place, and	d due to th	ne ceuse(s)) and menner as stated.
296 SIGNATURE AND TITLE OF CERTIFIER	- A	^		29c. LICENSE NU	JMBER		29d. DAT	E SIGNED	(Month, Day, Year)
CSCN CAT		. 5		D23962			J	anuar	cv 26 1995
30. NAME AND ADDRESS OF PERSON WHO C									
Scott D. Friedman		403 Marve	l Court	, Eastor	1	Md.	2160	1	
31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SI	SNATURE A VOID OF							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the fours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to bunial, cremation, or remoral. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT, if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

JAN 3 0 1995

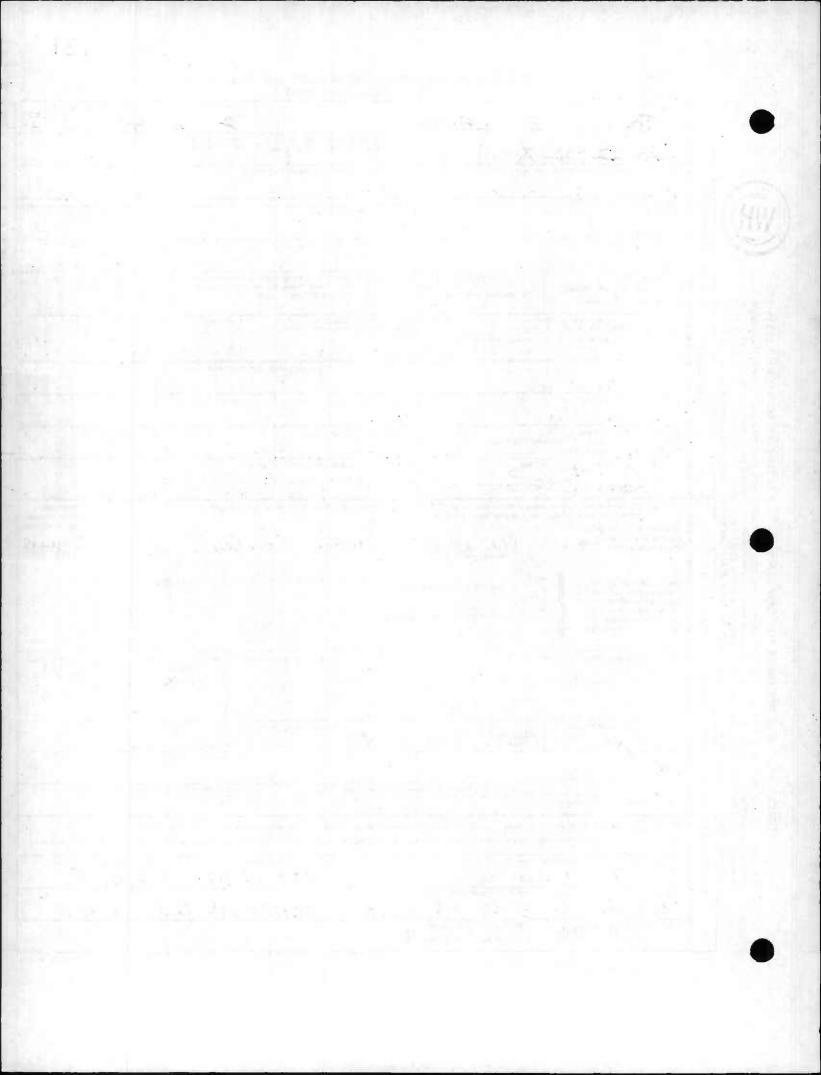
200 S 740

32. REGISTRAR'S SIGNATURE

31. DATE FILED (

1995

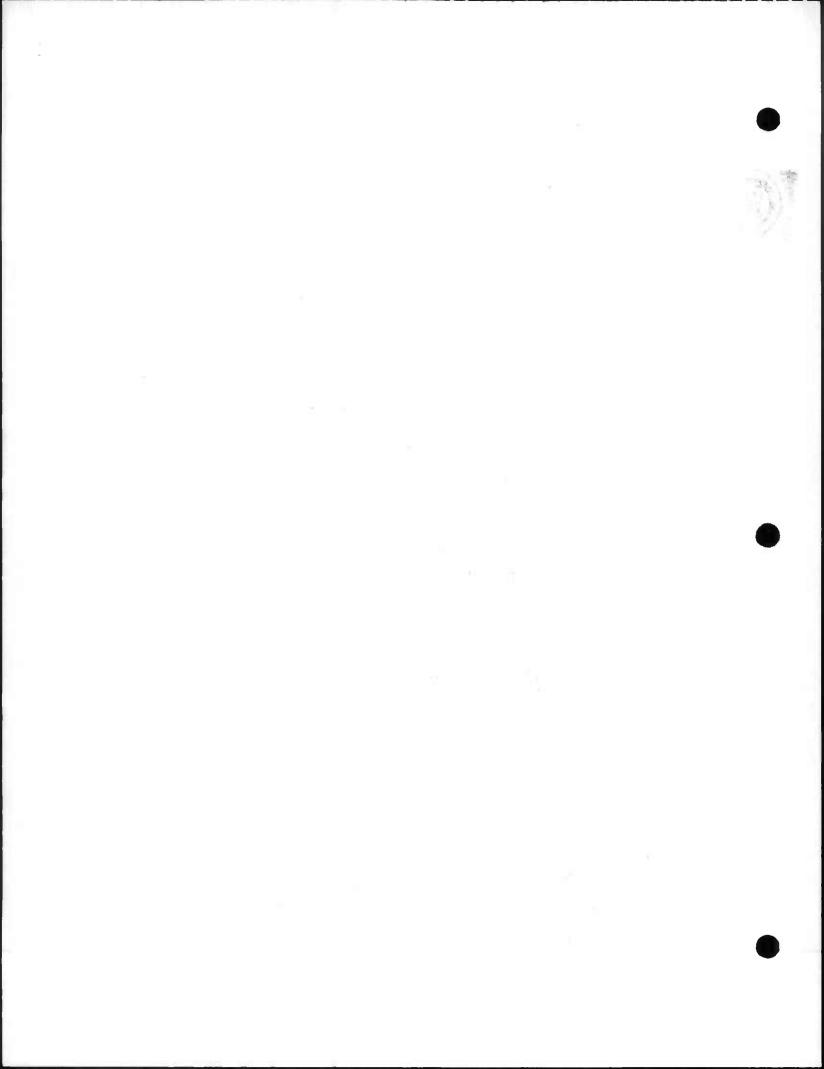
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO 3. TIME OF DEATN 35 AM 8. BIRTHPLACE (State or Foreign Virginia 9c. COUNTY OF DEATH Anne Arundel 10d. INSIDE CITY 1 YES 2 1 NO 10g CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian, Black, White, etc. Specify: white 16b. KIND OF BUSINESS/INDUSTRY Marine 20c. LOCATION - City or Town, State Gloucester Co. . VA Approximate interval Between Onset and Death 2 mars 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 YES 2 NO 26d. DESCRIBE HOW INJURY OCCURED 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) 6/95



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or iten

	- 1
1	
-	
	offfied at once.
	must be no
al,	examiner
on, or remov	e medical
fal, crematic	event, th
prior to bur	traumati
al Hygiene	or other
and Ment	any Injury,
of Health	SM0
Dept :	m 23 sh

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			MENTA	L HYGIENE				
	1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH		3.	TIME OF DEATH	
	Evelyn	Irene	L	INTON		Febr	uary 5	, 1995	AR	07:30 a M	
	4. SOCIAL SECURITY NUMBER		X 8. AGE (In yrs, lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH								
	214-10-2658	1 □ M 2 ☒ F 8	37 YRS.	nber 26,	ber 26,1907 Maryland						
~	9a. FACILITY NAME (If not institution, give street		9		R LOCATION OF D	EATH		9c. COUNTY			
0	1720 North Market	Street		Frede	rick			Fred	eri	ck	
EC	10e. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION				10	d. INSIDE CITY LIMITS?	
2	Maryland Fre	derick	F	rederic	k					LIMITS?	
FUNERAL DIRECTOR	100. STREET AND NUMBER 1720 North Market	Street		101	21701			10g. CITIZEN		T COUNTRY?	
Š	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DEC	ENDENT OF HISPAI	NIC ORIGI	17 (Specify Yea			American Indian,	
	1 Never Married 2 Married	FORCES? 1 YES	2 NO ATES	If yes, spo	city Cuban, Maxica	en, Puerto	Rican, etc.)		Black, W	hite.	
р ву	3XWidowed 4 □ Divorced									112.00	
	15. DECEDENT'S EDUCA (Specify only highest grade co	empleted)	16a. OECEDENT'S US (Give kind of wor life, Do NOT use r	VAL OCCUPATION done during mos	N st of working	168	. KIND OF BUS	INESS/INDUST	RY		
1	Elementary/Secondary (0-12)	College (1-4 or 5+)	Cafeteri			S	chool S	System			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			_	18. MOTHER'S NA	MF (First	Miridia Maidan S	(umama)	_		
Ü	Clifford	S.	COCKMAN		Ethe		madio, maidair c	ABRECI	T		
TO BE	19a. INFORMANT'S NAME (Type/Print)		196. MAILING AL	DRESS (Street a	nd Number or Rural	Route Num	ber, City or Town	State, Zip Cpo	(e) 1	01.700	
۲	Russell Lee Lintor	1	1491 We	st Nin	th St.,	Fred	erick,	Maryla	and	21702	
	20a. METHOD OF DISPOSITION 1.6.] Burlel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)		PLACE AND DATE OF			1995		ation – city lerick		sum ryland	
	21. SIGNATURE OF FUNERAL SERVICE LICEN		3010 011100	22. NAME AN	D ADDRESS OF FA	CILITY				-	
	* Richard &	Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, MD 21701									
	23. PART I. Enter the diseases, or con	mplications that was		1106 Ea	ist Churc	ch St	, Fred	erick.	MD		
	shock, or heert fallure. Lis	at only one cause on a	ech line.	onter the mo	ae or dying, suc	il as Call	arec or respir	etory errest,		Approximate Interval Between Onset and Deeth	
	IMMEDIATE CAUSE (Fine) disease or condition Arteriosclerotic Cardiovascular Disease Arteriosclerotic Cardiovascular Arteriosclerotic Cardiovascular Arteriosclerotic Cardiovascular Arteriosclerotic Cardiovascular Arterioscler										
	resulting in death) a.		CONSEQUENCE OF):	- Out a	LOVEDCE	-202	2100			Years	
Z	Sequentially list conditions 6.	Hypother								2 hours	
Ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	OUE TO (OR AS	CONSEQUENCE OF):								
FIG	CAUSE (Disease or Injury C.	DUE TO (OR AS	CONSEQUENCE OF):								
CERTIFICATION	that initiated events resulting in death) LAST	,	,								
	DADT II. Other significant conditions										
PHYSICIAN: MEDICAL	Alzheimer's D				cauee given in	Pert I.	24a. WAS AN A PERFORM		AM	RE AUTOPSY FINDINGS AILABLE PRIOR TO	
ğ	Alzheimer 5 D	isease _	Dement1a	1			1 TES 2	NO NO		OMPLETION OF CAUSE DEATH?	
Σ	DID TORACCO LISE CONTRIL	DUTE TO CALLEE O	EDEATH VEC		LINICEDTAN				1 [YES 2 NO	
AN	DID TOBACCO USE CONTRI	BUTE TO CAUSE C	26. PLACE OF DEATH		UNCERIAII	иЦ					
SIC		IOSPITAL:	0	THER:	5 Residence		(Paratha)				
Ħ	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME C	F 28c. INJU	JRY AT		CRIBE HOW IN	JURY OCCURE	D		
ВУР	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR		RK? ES 2 NO	_					
	3 Suicide 8 Could not be	28a. PLACE OF INJURY building, atc. (Spe-	— At home, ferm, stre	et, factory, office			ATION (Street an or Town, State)	d Number or R	ural Rout	e Number,	
	4 Homicide determined					,	or rown, otaloy				
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA EXAMINER:	AN: To the best of my know On the besis of examination							usein) e-	nd manner as steed	
	29M SIGNATURE AND TITLE OF CERTIFIER	- 1	1 -1-	4.5	29c, LICENSE NUI		7			onth, Day, Year)	
BE	X Sut RA	2 RA	uls 11	11)	D0986			Feb.			
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF DE	ATH (ITEM 27) (Type, Pg	AL)							
}	Dr. Robert R.R. F	Roberts, M.1)., 15 Wes	t Sever	nth Stre	et,	Frederi	ick, M	D 21	.701–4599	
	FEB 06 1995	32. REGISTRAR'S SIGN	ATURE Randally								



TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR	,	STATE OF I	MARYL					HEALTH		MENTA	L HYGIEN	E			
1. DECEDENT'S NAME (First,	Middle, Last)										OF DEATH			3. TIME OF D	EATH
Thoma	as	Melvin	1	LE	SCAL	LEET	•	Sr		Feb:	ruary	, 19	95°	5:35	am w
4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs. las	birthday)	IF UNDER 1	YEAR	IF UNDER	24 HRS.	7 DATE	OF BURTH		_	IPLACE (State o	
218-30-992	1	1 XM 2 - F		87	YRS.	MONTHS	DAYS	HOURS	MIN.	Mar	29,19	7	Count		
9a. FACILITY NAME (If not in:		reet and number)				9b. CITY,	TOWN	OR LOCATION	ON OF DI		,		NTY OF D	-	
Homewood R	etirem	ent Cent	er					erick				111 7.50		erick	
RESIDENCE OF DEC	EDENT											1			
Manage 1	10b. COUNTY	J ! - 1-			1,11	, TOWN OF								10d. INSIDE C	ITY
Maryland	Free	derick				Frede	rı	CK						1 TES 2	™ NO
5820 Genes	is Lan	e, #520					10	r. zip codi 217				,	J.S.A	WHAT COUNTRY	7
11. MARITAL STATUS		12. WAS DECEDEN									N? (Specify Yes	or No-	14, RACI	E American I	ndlen,
1 Never Married 2		FORCES?			0			ecify Cuba 2 X NO			Rican, etc.)		Spec	k, White, atc.	
3 ☑ Widowed 4 ☐ Divo	rced		20 347					- UL					Орос	" Whit	.e
15. DEC (Specify only	EDENT'S EDUC highest grade	ATION completed)		(Gi	ve kind of w	USUAL OCC		ON ost of working	ng	16	. KIND OF BUS	SINESS/IN	DUSTRY		
Elementary/Secondary (0	-12)	College (1-4 or 5	+)		Do NOT use						Auto	Commi	00 ('antan	
8				Aut	o me	chani	LC				Auto S				
17. FATHER'S NAME (First, Mi	Gilmor	. IE	SCAL	ਾ ਫਾਵਾ	,			16. MOT	HER'S NA	ME (First	Middle, Meiden	Superio	E	ives	
Harry 19a. INFORMANT'S NAME (7)		e rr	iOCAL					Et	. ud	1	viae	LAN	/ES		
Mrs. Patri		n Chaffi	n								ncrod,				
		ii Cilatti		_					ur t						
20s. METHOD OF DISPOSITI 1 X Burlel 2 Crematio 4 Donation 5 Other	n 3 🗆 Remo	oval from State	cen Me	etery, crei	nd DATEO	her place)	one	ame of	Fe	b: 7	1995 F	rede	City or To	, Mary	land
21. SIGNATURE OF FUNERAL	L SERVICE LICI	ENSEE /	111	Juile	OIIV	22. N	AME A	ND ADDRES	SS OF FA	CILITY	17/77 1	reac	LICK	, Illiny.	Land
Ketth	men	- Kuber	m	MC	00021						P.A. Fu t. Free)1
23. PART i. Enter the of	saasea, or co	omplications the	t caused	tha da	ath. Do n									Approx	imata
iMMEDIATE CAUSE (Fin		List only ona car	ise on a	D	•										Between and Death
resulting in death)	→	OUE TO	100 46 4	CONCEC	UENCE OF									146	ans
		DUE TO	(UH AS A	CONSEC	UENCE OF):								'	
Sequentially list conditi if any, leading to immed	dieta	DUE TO	(OR AS A	CONSEC	UENCE OF):									
cause. Enter UNDERLYi CAUSE (Disessa or inju			(00.10.1												
that initiated avents requiting in death) LAS	,	DUE TO	(OR AS A	CONSEC	UENCE OF):								1	
and the state of t														-	
PART II. Other algnifica	nt conditions	contributing to	daath b	ut not n	sulting in	n the und	erlyin	g cause (givan in	Part i.	24s, WAS AN	AUTOPSY	24b	. WERE AUTOPS	Y FINDINGS
D, abe											PERFOR			AMAILABLE PRI	OR TO
Ischem		400		Di	L .						1 - YES 2	NO		DF DEATH?	
DID TOBACCO U		HELLI TO CA	USE O	-		S 🔯 N	οГ	1 IINC	ERTAII	N [1 TES 2	□ NO
25. WAS CASE REFERRED TO		abott to cr	.001 0			H (Check or			EKIMI	1 11					
EXAMINER?		HOSPITAL:	FR/Oute			OTHER!		ne 5 ☐ Re	aldanaa	e 🗆 Out-	on (Decell)				
27. MANNED OF DEATH		28a. DATE OF		atront 0	28b. TIME			JURY AT	ISIGENCE		SCRIBE HOW II	NJURY OC	CURED		$\overline{}$
	Pending	(Month, E	Day, Year)		INJU	JRY M	1 🗌	DRK?	NO						
2 Calalda	Investigation	28e. PLACE C	F INJURY	- At ho	ne, farm, si	trast, factor				28f, LO	CATION (Street a	ind Numbe	or Rumi I	Poute Number	
- "	Could not be determined	building,	atc. (Spec	cify)						City	or Town, State)			,	
29a. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my know	ledge, da	ith occurre	d at the tim	e, data	and place	and dua	to the ca	use(s) and mar	ner as ste	ted.		
onel		: On the basis of a) and manner a	s stated.
296. SIGN TURE AND TITLE	OF CERTIFIER						_	29c. LICE	NSE NUI	WBER		29d, DAT	E SIGNED	Month, Day, Ye	er)
Aula	3							P	26	511	6	•	216	95	

Mey

32. REGISTRAR'S SIGNATURE
Java Maustan Randall

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tra

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

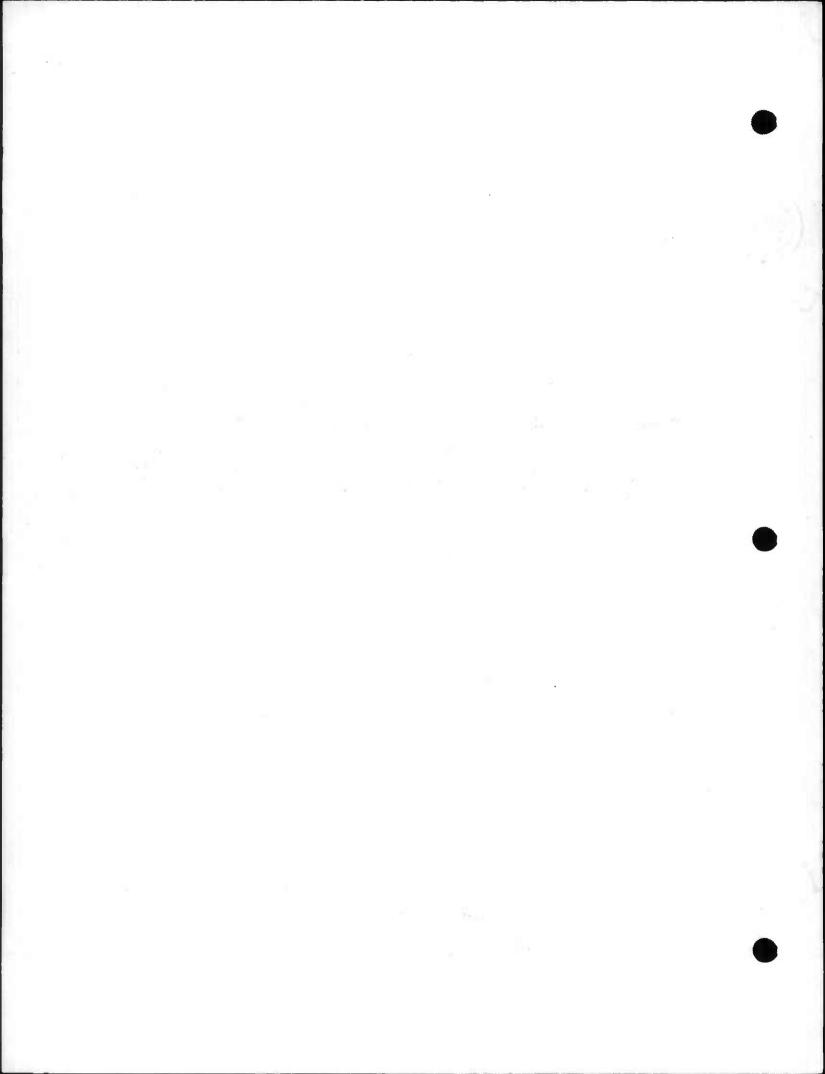
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DIVISION	- 1
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Ε) <u>A</u>	NI	EL	
4.	ş	OCIAL	SECU	F

	1 - STATE REGISTRAR	SIAIE UF MA	CERT	IFICATE				EG. NO			
	1. OECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DEATH		3. TIME OF OEATH	
	DANIEL	WILLIAM		LIG	нт S	R.	FEBRUA		MY	YEAR 1995 3:30 A M	
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	. AGE (In yrs. lest birtho				7. DATE OF E	HTRU		8. BIRTHPLACE (State or Foreign	
	218-24-8772	1 XM 2 - F	78 YR	S. MONTHS	DAYS HOURS	MIN.	(Month, De		1916	Country) MARYLAND	
	9a. FACILITY NAME (If not institution, give	street and number)		9b. CITY, 1	OWN OR LOCAT	_		10	_	INTY OF DEATH	
8	MEMORIAL HOSPITA	MEDICAL	L								
5	RESIDENCE OF DECEDENT			LCOMB	EKLAND				I ALL	EGANY	
DIRECTOR	10a. STATE 10b. COUN	TY	10c.	CITY, TOWN OR	LOCATION					10d. INSIDE CITY	
		ERAL_		RIDGEI	EY					1 TES 2 K NO	
¥.	10e. STREET AND NUMBER				101. ZIP CO					IZEN OF WHAT COUNTRY?	
9	ROUTE 2 BOX :	-			26	753			U	SA	
FUNERAL	11. MARITAL STATUS 1 Never Married 2 X Married	12. WAS DECEDENT E	YES 2 NO	13. W	S DECENOENT	OF HISPANI	C ORIGIN? (S.	pecify Ye	a or No—	14. RACE — American Indian, Black, White, etc.	
B	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES		YES 2 X NO			11, 4144)		Specify: WHITE	
	15. OECEDENT'S ED	UCATION	WW II							l	
	(Specify only highest grad	le completed)	(Give kind	NT'S USUAL OCC of of work done du OT use retired.)	ring most of work	ing	16b. KIN	ID OF BU	SINESS/IN	DUSTRY	
2	Elementery/Secondary (0-12)	College (1-4 or 5 +)	FAR				AGI	RTCI	JLTU	RE	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					FLIFFOND ALAM	NE (First, Middl				
		LIGHT				LDRE		ESS]			
BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAII	LING ADDRESS (in Code)	
2	CHARLOTTE L.	LIGHT								VA. 26753	
	200. METHOD OF DISPOSITION		20b. PLACE AND DA	ATE OF DISPOSIT	ON (Name of	- 111	DATE			City or Town, State	
	1 XBuriel 2 Cremetion 3 Rei	moval from State	PINTO E	CENNON	ITE C	EM. I	FEB 7	1		, MARYLAND	
1	21. DIGHATURE OF FUNERAL SERVICE L	ICENSEE	0	22. N/	ME AND ADDR	ESS OF FAC					
	Dougkas	PH	Lw							LLS MORTUARY LE, MD 21502	
	23. PART I. Enter the diseases, or	complications that c	aused the death. I								
	shock, or heart failure IMMEDIATE CAUSE (Final	. Liet only one cause	on each line.	- /						interval Between Onset and Daath	
	disease or condition	K	erh- 6	i have						8	
	resulting in death)	DUE TO (9	ASIA CONSEGUENO	E OF):	-					o rey	
z	Water Paris and Control of the	. 1	NEUMO	ONIH						12	
5	Sequentially list conditions, if any, leading to immediate	DUE TO (O	R AS A CONSEQUENC	E OF):						1	
2	CAUSE (Disease or injury	c									
	that initiated events resulting in death) LAST	DUE TO (O	R AS A CONSEQUENC	E OF):							
CERTIFICATION		d,									
	PART II. Other eignificent condition	ns contributing to de	eth but not resulti	ng in the und	erlying ceuse	given in F	Pert I. 24		AUTOPSY		
MEDICAL	D. I. (- Chm	is Ken	Pall	Reu	rt 1	(VA	PERFO		AMAILABLE PRIOR TO COMPLETION OF CAUSE	
		/		/	UNC	ATS		, 120		OF DEATH?	
	DID TOBACCO USE	CONTRIBUTE T	O CAUSE C	F DEATH	YES [NO	Ē l			10.120 10.110	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				26. PLACE OF	DEATH (Chec	ck only one)				
Sic	EXAMINER?	HOSPITAL:	R/Outpatient 3 DO	OTHER:	g Home 5 🗆 F	lesidence 6	Other (Sc	nacify)			
호	27. MANNER OF DEATH	28e. DATE OF IN (Month, Day,		TIME OF 2	Bc. INJURY AT		28d. DESCRI		INJURY OC	CCURED	
BY	Netural 5 Pending 2 Accident Investigation	(WORL), Day,	lear)	INJURY M	WORK?	□ NO					
	3 Suicide 8 Could not be	28a. PLACE OF I	NJURY — At home, fer	rm, street, factor	y, office		281. LOCATIO	N (Street	and Number	or or Rural Route Number,	
COMPLETED	4 Homicide determined		a (dpoorly)				City or io	WII, State)		
7	29e. CERTIFIER (Check only) 1 CERTIFYING PHYS	SICIAN: To the best of my	y knowledge, death oc	curred at the tim	e, date and plac	e, and due t	to the cause(s) and ma	nner as ata	rted.	
8										he cause(a) and manner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIE		2 1			ENSE NUM				TE SIGNED (Affirm, Day, War)	
BE		N.H.Ko	nillhan						•	2/1/0-	
2		*		Time Print)	101	9318	_	_		10/75	
-	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE	OF DEATH (ITEM 27)	type, rinn)						/	
-	N. RANJITHAN M.D			The state of the s	ERLAND,	MD	21502				
-		., 517 OLD	TOWN ROAD	The state of the s	ERLAND,	MD	21502				



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er death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ne notified
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Hygiene p	or other
Mental	Siery.
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State	Hem
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death	s mai
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HYGIENE REG. NO. OF DEATH 3. 02,1995 A TIME OF OEATH 10:10 A							
DAY YEAR							
BIRTH Country 1958 BIRTHPLACE (State or Foreign Country) MD							
9c. COUNTY OF DEATH MONTGOMERY							
10d. INSIDE CITY LIMITS? V YES 2 \(\text{N} \) NO							
10g. CITIZEN OF WHAT COUNTRY? USA							
(Specify Yea or No— 14. RACE — American Indian, Black, White, atc. Specify: White							
dentistry							
17. FATHER'S NAME (First, Middle, Last) Lawrence Franklyn Lockard 18. MOTHER'S NAME (First, Middle, Meiden Surname) Carol Jean Marker 19. INFORMANT'S NAME (Type/Print) 19. MAILING ADDRESS (Street and Number of Burel Brush Aumber City or Taylor State Tipe Code)							
or, City or Town, State, Zip Code) Lland, MD 21502							
6 Cumberland, MD							
Home 02							
ac or respiratory arrest, Approximate Interval Between Onset and Death							
if any, leeding to immadele cause. Enter UNDERLYING CAUSE (Dissesse or injury that initiated events resulting in death) LAST							
-							
24a. WAS AN AUTOPSY PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE							
PERFORMED? YES 2 NO NO NO NO NO NO NO NO NO NO							
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BE COMPLETED 9

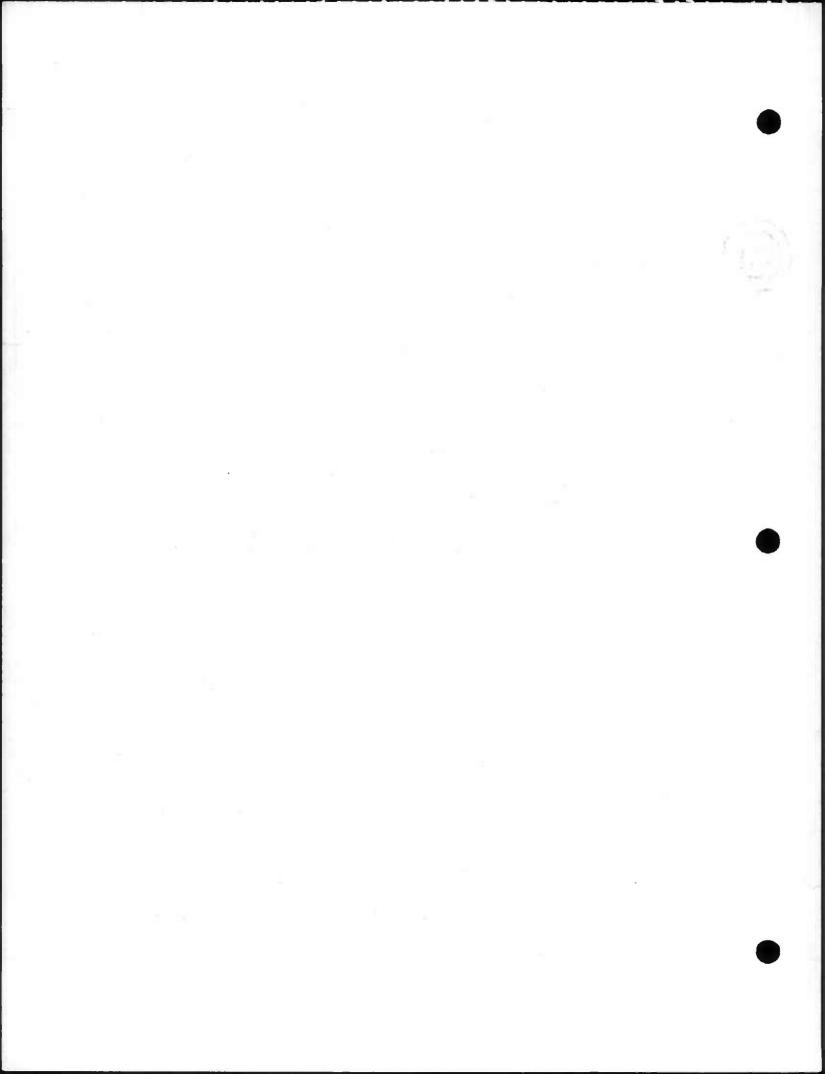
284 SIGNATURE AND TITLE OF CERTIFY

29a. CERTIFIER (Check only one)

29c. LICENSE NUMBER OCME

29d. DATE SIGNED (Month, Day, Year) FEB.03,1995

Penn Street, Baltimore, Maryland 21201 111



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2, 3 should

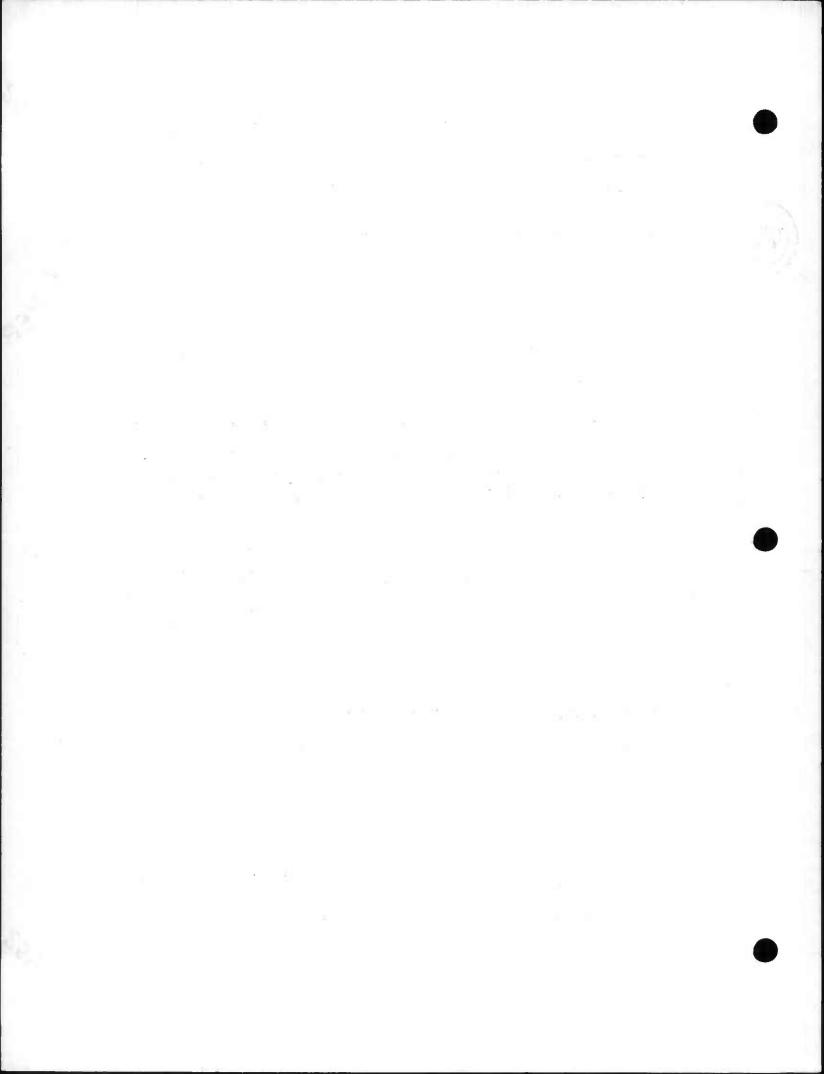
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	CARL E	EDWARD	LOWERY			FEBRUARY 2	1995	12:58 p M		
		5. SEX 6. AG	E (In yrs. lest birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) JAN 21, 1		HPLACE (State or Foreign		
OR	9a. FACILITY NAME (If not institution, give stre 80 GREENE STREET	et and number)			OR LOCATION OF DE ERLAND		Sc. COUNTY OF C			
딥	RESIDENCE OF DECEDENT 10e. STATE 10e. COUNTY	10b. COUNTY 10c. CITY, TOWN OR LOCATION						10d, INSIDE CITY		
DIRECTOR	MD ALLI		CUMBERLA				1 X YES 2 NO			
FUNERAL	80 GREENE STREET	Г		1	21502		USA	WHAT COUNTRY?		
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 XDIvorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 2 NO	If yes, s		IIC ORIGIN? (Specify Yas n, Puarlo Rican, atc.)		E — American Indian, ik, Whita, etc. :://y: WHITE		
<u>E</u>	15. DECEDENT'S EDUCA (Specify only highest grade co		16a. DECEDENT'S			16b. KIND OF BUS	SINESS/INDUSTRY			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	LABOE		ost or worlung	ICE CRE	AM MANUF	ACTURING		
Š	17. FATHER'S NAME (First, Middle, Last)			-	18. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)			
BE (WALTER LOWERY				SADII	E DeVORE				
2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow				
	BETTY J. PIPER					NW, CUMBE	RLAND, MI	D 21502		
	20e. METHOD OF DISPOSITION 1. Burlai 2 Cremelion 3 Remov 4 Donation 5 Other (Specify)	ral from State	ob. PLACE AND DATE of the complex of	of disposition (f ther place) MEMORIA	L PARK 2	DATE 20c. LO	CATION — City of TO VALE, MD	own, State 21502		
	21. SIGNATURE OF FUNERAL SERVICE LICES	our last		HARV	EY H. ZE	CILITY IGLER FUNE	RAL HOME	21302		
-	23. PART I. Enter the diseases, or co	mulications that caus	ed the death. Do r	HYNL	MAN, PA	15545-06	36	L Annual sale		
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, interval Batween Onset and Death disease or condition. IMMEDIATE CAUSE (Final disease or condition Cause Of St.									
	disease or condition resulting in death) a. Conglistic Heart Failure Due to Gras a consequence of: Discourse of the control									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events Dilated Ischemic Cardio myo pathy 10 y Due to (or as a consequence of): Coronam artery Disease Due to (or as a consequence of):									
SERTIFI	that initiated events resulting in death) LAST d.									
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
IEDICAL	Renal Failure Performed?							AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
. M	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO									
M	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. 1	LACE OF DEATH (Ch	eck anly one)				
Sic	. The same of the first	HOSPITAL:	ulpatient 3 🗆 DOA	OTHER: 4 Nursing Ho	me 5 KRealdence	6 Other (Specify)				
Y PHYSICIAN:	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJUR (Month, Day, Year	E OF INJURY 28b. TIME OF 28c, INJURY AT 28d. DESCRIBE HOW INJURY OCCURED							
TED BY	2 Accident Investigation 3 Suicide 6 Could not be detarmined 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)							Route Number,		
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICI 2 MEDICAL EXAMINER:	AN: To the best of my kno						a) and manner as stated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIER	fall,	M.D		1615	MD MD		(Month, Day, Year) 02, 1995		
2	30. NAME AND ADDRESS OF PERSON WHO RAGAA FADL, MD, 9				. MD 21	.502				
	31. DATE FILED (Month, Day, Year)	22. REGISTRAR'S SIG	SNATURE	- LIKE THAT	, 1111 21	. 504				
	FEB 0 3 1995	is Davidson	tardall							

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and least. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial that be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

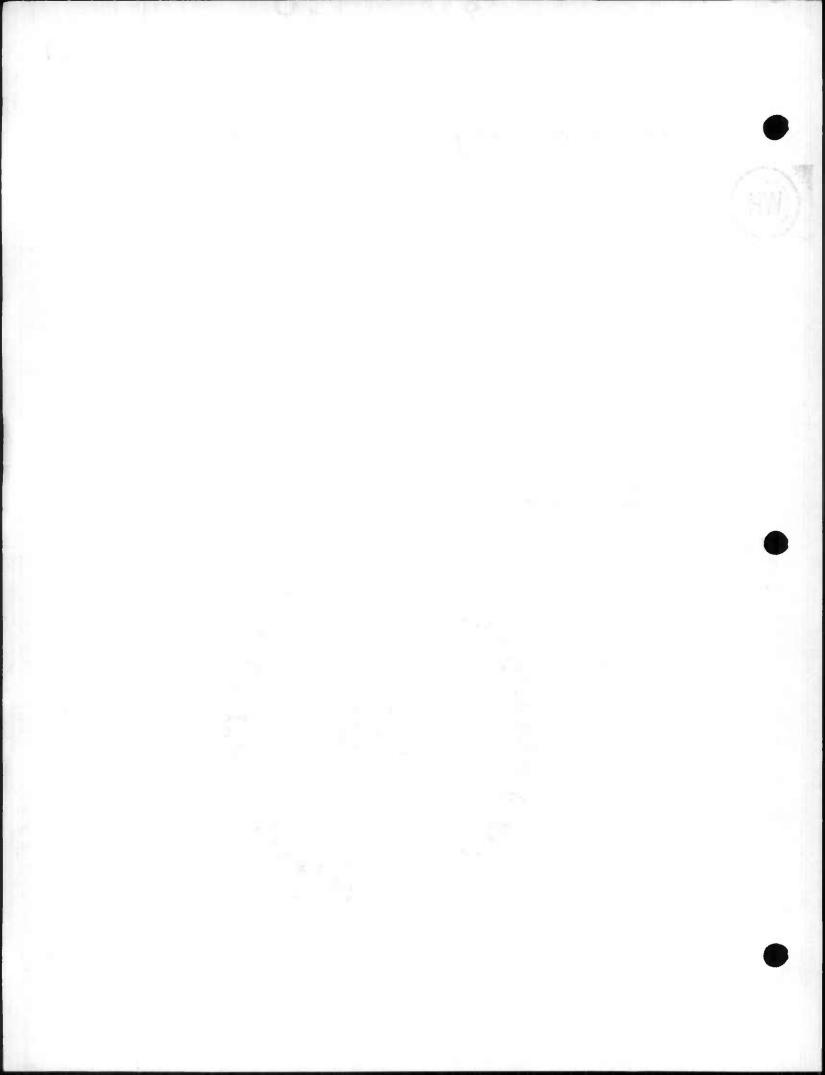
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020



REGISTRAR CERTIFICATE OF DEATH REGISTRAR	FOR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
1120.14	REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	AND / DEPAR	TMENT OF H	IEALTH AND I	MENTAL HYGIE		
	1. DECEDENT'S NAME (First, Middle, Last)	,				2. DATE OF DEATH		3. TIME OF DEATH
	Miriam B.	Lenny	_			МОНТИ		EAR 5:15 M
	4. SOCIAL SECURITY NUMBER		n yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
. 1	077-16-0505	1 DM 2 DF 92	YRS.			Sep. 12,	02	Lithuania
m	Sa. FACILITY NAME (If not institution, give str			9b. CITY, TOWN	OR LOCATION OF DE	EATH	9c. COUNTY	OF DEATH
힏	Rockville Nursing	g Home		Rockvi1	1e	tgomery		
DIRECTOR	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION	-		10d. INSIDE CITY
	Md. Monte	gomery	Ro	ckville				N YES 2 NO
FUNERAL	10e. STREET AND NUMBER			1	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
ÿ	303 Adclare Rd.				0850		US	
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, sp	ecify Cuban, Mexica	NIC ORIGIN? (Specify in, Puerto Rican, etc.)	Yes or No- 14.	. RACE — American Indian, Black, White, atc.
B	2 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	ITES	1 TYES	2 NO Specify	y:		SpecifyWhite
G	15. DECEDENT'S EDUC (Specify only highest grade of	ATION	16a. DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND OF I	BUSINESS/INDUS	TRY
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	work done during mo se retired.)	at or worrang			
M	12		Housew	ife		Own Ho		
	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maid	en Sumame)	
띪	Edward Bank 19a. (NFORMANT'S NAME (Type/Print)		I		Fannie			
유	Rhoda Hanik					Route Number, City or 1 ace Potom		
	20a. METHOD OF DISPOSITION 12 Buriel 2 Cremation 3 Remo	wal from State 20b.	PLACE AND DATE	OF DISPOSITION (Ne	al Garde	DATE 20c.	LOCATION City	
	4 Donation 6 Other (Specify)		ing Davi	22 NAME AL	ID ADDRESS OF EA	CHITY		Church, Va.
	180.11	5.0		Edwar	d Sage1	Funeral D	irectio	n e, Md. 20852
	23. PART I. Enter the diseases, pr c	omplications that caused	the death Do					
	shock, or heart failure. L	List only one cause on ea	ich ilne.	ot enter the mo	de of dying, suc	n as cardiac or rea	spiratory arrest	interval Between
	IMMEDIATE CAUSE (Final disease or condition	Drouma	0000					Onset and Death
	resulting in death)							
z		Alzhei	mer'	5 DISA	ease			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O	F):				
3	CAUSE (Disease or injury	Huper	CONSEQUENCE OF					
Ē	that initiated events resulting in death) LAST		OONSEADENCE OF	· ·				İ
		J						
AL.	PART II. Other algoriticant conditions	contributing to death bu	ut not resulting	in the underlying	g cause given in		AN AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC						1 _ YES	2 NO	OF DEATH?
X						-		1 TYES 27 NO
AN	25. WAS CASE REFERRED TO MEDICAL			24 04	ACE OF BEITH ON	ant anti-anal		
SIC	EXAMINER? 1 YES 2 THO	HOSPITAL:	etlant 2 🗆 DOA	OTHER:	ACE OF DEATH (Ch			
PHYSICIAN:	27. MANNER OF DEATH	28s. DATE OF INJURY	26b. TIM	E OF 28c, INJ	URY AT	6 Other (Specify) 28d. DESCRIBE HON	W INJURY OCCUR	IED
ВУ Р	1 Netural 5 Pending	(Month, Day, Year)	IN.		PRK?			
	3 Suicide 6 Could not be	28e, PLACE OF INJURY building, etc. (Speci	— At home, farm,	street, factory, offic	•	261. LOCATION (Street		Rural Route Number,
TED	4 Homicide determined	banang, etc. (Speci	-77		. 6	City or Town, Stu	ite)	
29a. CERTIFIER (Check only one) 29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
							ause(s) and manner as stated.	
ш	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI	MBER	29d. DATE S	IGNED (Month, Day, Year)
TO B	SHange	no-			D-43	3272	11/	29/95
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH UTEM RT) (Type	Rock	Ville	md	200	SI HANJURA
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA		100	(116	114	408	//
	JAN 31 1995	Julia Davides	Rendall					
	1800							DHMH-16 Bay 1/89

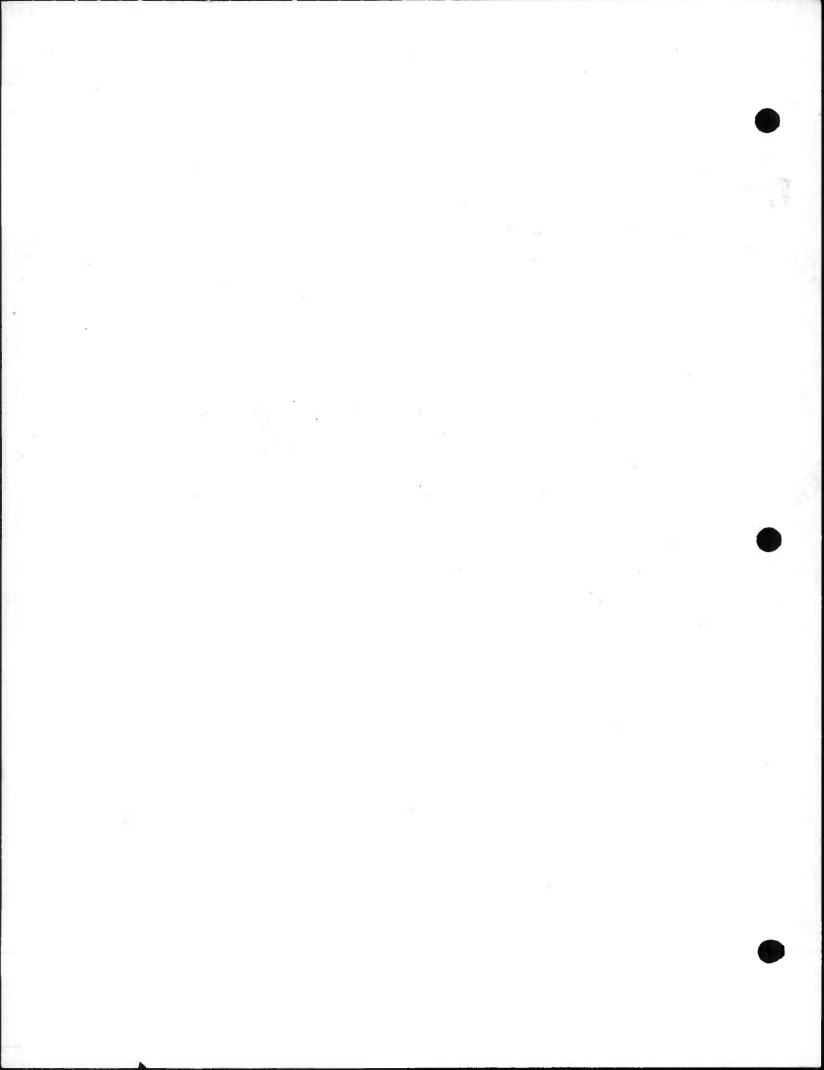


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1 - FOR STATE REGISTRAR 1. DECEDENT'S NAME (First, MI		RYLAND / DEPARTMENT CERTIFICATE	OF DEATH	REG. NO.	To gomery
Amendeo	J # 10b	#195-	1/31/95	MRT	15 04728 Montameru

	1 - STATE REGISTRAR	STATE OF I	WARYLAN	D / DEPAR CERTIF	ICATI	OF H	DEAT	AND I	MENT	AL HYGIEN REG. NO	E	TOYL	Jones
	1. DECEDENT'S NAME (First, Middle, Last)								2. DAT	E OF DEATH		YEAR	3. TIME OF DEATH
	Clifford "E	" Long	est									995	12:40 A M
- 6	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yr	s. lest birthday)	IF UNDER		IF UNDER		7. DAT	E OF BIRTH oth, Day, Year)		8. BIRTH	PLACE (State or Foreign
	305-18-3795	1 🔀 M 2 🗌 F	1 X M 2 F 73 YRS. MONTHS DAYS HOURS MIN.						. 23.19	21	Countr	**	
-9	9e. FACILITY NAME (If not institution, give	street end number)			9b. CITY	, TOWN C	R LOCATIO					NTY OF D	
Ю	Rockville Nursi	ng Home				Rock	vil1	е	Montgomery				merv
DIRECTOR	RESIDENCE OF DECEDENT 10s. STATE 10s. COUNT	Y Wa 1		400 CIT	Y, TOWN C	20 1 0017	1011						
		Montgo	mery					h					10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	gomery	- 0				hers						1 YES 2 NO
R	13012 Darnestown	Road				101		878					tates
FUNERAL	11. MARITAL STATUS		T EVED IN II S	ADMED	142	WE 050							
<u> </u>	1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	XXYES 2	NO	1 3	It yes, spe	cify Cube	n, Mexica	n, Puerti	iN? (Specify Yes o Rican, etc.)	or No-	14. RACE Black	American Indian, c, White, etc.
B	3 Widowed 4 Divorced	1942-1		5		I U YES	2 📉 NO	Specify	r:			Speci	w. White
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION		DECEDENT'S	USUAL O	CCUPATIO	N		.10	5b. KIND OF BUS	SINESS/IND	USTRY	***************************************
	Elementary/Secondary (0-12)	College (1-4 or 5	r)	(Give kind of title. Do NOT us	work done is se retired.)	dunng mo:	st of worldn	g					
를		5+		Offic	er					United	Stat	es N	avy
ġ l	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	ER'S NA	ME (First	, Middle, Meiden	Surneme)		
w l	Aaron I	ongest					Z	ella	Br	ock			
0	19a. INFORMANT'S NAME (Type/Print)									mber, City or Town			,
-	Marcille M. Longe	st								aithers	burg	, MD	20878/
	20e. METHOD OF DISPOSITION	oval from State	20b. PLA	CE AND DATE	OF DISPOS	ITION (Na	me of 2/	3/95	DA	TE 20c. LO	CATION —	City or To	wn, State
	4 Donation 5 Other (Specify) 21. SCHATURS OF FUNERAL SERVICE LIE	Arrange	Arí	ington	Nat	iona	1 Ce	mete	ry				irginia
	91-0	T W	-		R R	ober	L ADDRES	Pum	phr	ey Fune	ral	Home,	/
	23. PART I. Enter the diseases, or	J. ThU		M00348	A	venu	e, R	ockv	TTT	e, mary	Land	208	mery 50-2805
L CERTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):								Interval Between Onset and Death St. 1994 1 week 2 weeks				
MEDICA	PERFORMED? 1 TYES 2 NO OF D								AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2X NO				
	DID TOBACCO USE CONT	RIBUTE TO CA					UNC	ERTAIN	1 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. P	LACE OF DEAT	H (Check of								
2	1 ☐ YES 2 MO	1 Inpatient 2		n 3 🗆 DOA			5 🗆 Res	sidence	8 🗆 Oth	er (Specify)			
5	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF (Month, Di		26b. TIM	URY	28c. INJU WOR			28d. DE	SCRIBE HOW IN	JURY OCC	CURED	
ā	2 Accident Investigation				М		ES 2	NO					
E ED	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, term, street, factory, office City or Town, Stelle) 28t. LOCATION (Street and Number or Rural Route Number of Rural Route Number or Rural Route Number o								oute Number,				
29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(e) and my one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(e) and my opinion one)											end menner as stated,		
- 18	29b. SIGNATURE AND TITLE OF CERTIFIE	R		, ,		~	29c. LICE	NSE NUM	BER	T	29d. DATE	SIGNED	(Month, Day, Year)
	Frank	e IN	Who	rul	M	()		9785					y 30, 1995
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUS	E OF DEATH	(ITEM 27) (Type,	Print)	/-1					J 41	ar	, 50, 1555
	Frauke Westphal,	M.D. 80	9 Vei	rs Mil	l Roa	ad,	Rocky	vill.	e. N	Marylan	d 20	0851	1
	JAN 31 199	5 Julia d							. , .				

20+



24b. WERE AUTOPSY FINDINGS

FUNERAL DIRECTOR

BY

COMPLETED

2

CERTIFICATION

PHYSICIAN: MEDICAL

BY

COMPLETED

BE

2

223

notified at BE (

physician	burial-trans	
attending	ise as the	
hospitai or	ached for u	ce.
ed by the	uld be det	ed at on
y be retain	age 5 sho	be notifi
Page 6 ma	director, p	er must
ter death.	the funeral	al examin
nours af	filled in by	e medic
ed within .	completely al, cremati	event, tl
be execut	ilor to bun	Iraumatic
h certificat	Hygiene p	or other
at the deat	by the atte	y injury.
requires th	sen signed of Health	shows an
4: The law	cate has be State Dept.	Item 23
PHYSICIA	this certifi	arked, or
NITENDING	CTOR: After after death	28 is ma
PITAL DR /	ERAL DIRE	T: H item
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a work and refer death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-train be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
2	FÃ	=

1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND /	DEPART					MENTAL	HYGIEN REG. NO					
1. DECEDENT'S NAME (First, Middle, Las	1)							2. DATE (F DEATH	NAV.	MEAD	3. TIME OF	DEATH	
MABEL		LEI	BOWITZ					FEBR	UARY '	T,199	5 TEAR	9:50	AM	M
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		IF UNDER			R 24 HRS.	7. DATE C	F BIRTH		8. BIRTI	NPLACE (State	or Foreig	n
219-42-3757	1 🗆 M 2 💢 F	81	YRS.	IONTHS	DAYS	HOURS	MIN.	JAN.	27,	1914	TEX	KAS		
Sa. FACILITY NAME (If not institution, give	street and number)			96. CITY,	TOWN C	R LOCAT	ION OF D	EATH		9c. COU	INTY OF E	DEATN		
MONTGOMERY GE	NERAL HOS	PITAL		(OLNE	EY				MON	VTGON	IERY		
RESIDENCE OF DECEDENT			T 40											
			10c. CITY,				7					10d. INSIDE	?	
	TGOMERY		51	LVE		PRINC						1 TYES		,
10e. STREET AND NUMBER	O	T #001			101	ZIP COD						WHAT COUNT		
15107 INTERLA						2090					ITEI	STAT	ES	
11. MARITAL STATUS 1 Never Married 2 X Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AF						NIC ORIGIN:		a or No-	14. RAC Blac	E — American ck, White, etc.	n Indian,	
3 Widowed 4 Divorced	IF YES, GIVE V	MAR OR DATES A		1	YES	2 X NO	Speci	ffy:			Spec	WHIT	E.	
16. DECEDENT'S ED	DUCATION	16a DE	ECEDENT'S U	SUAL OC	CURATIO	NO.		165	KIND OF BL	ISINESS/IN	DUSTEY	MULI	E	
(Specify only highest gra		(G	ilve kind of wo	rk done d	uring mo	at of work	ing	1000	KIND OF BO	7511VE33/11V	DUSTAT			
Elementary/Secondary (0-12)	4		LAIMS	SUP	ERV]	SOR		S	OCIAL	SECI	JRITY	Y ADMI	N.	
17. FATHER'S NAME (First, Middle, Last)						18. MOT	NER'S N.	AME (First, M	iddie, Maide	n Surname)				
LEMUEL E. SHE	LBY							CLAIR						
19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING A	DDRESS	(Street a	nd Numbe	er or Rural	Aoute Numb	er, City or To	wn, State, Zi	ip Code)			
GEORGE LEIBOW	ITZ	1.	5107 I	NTE	RLAC	CHEN	DRI	VE #3	01-SI	LVER	SPR	ING, MD	.209	906
20a. METHOD OF DISPOSITION		20b. PLACE	OF DISPOSIT	TION (Nar	ne of cer	netery, cre	matory or		20c. L	OCATION -	City or T	own, Stata		
1 Donation 5 Other (Specify)	movel from State	MT. C	OMFORT	CR	EMA'	CORY			ALE	XANDE	RIA,	VIRGI	NIA	
21. SIGNATURE OF FUNERAL SERVICE	LICENSEE			22. P	AME AI	D ADDRE	COT	ACILITY DBERG	MEMO	RTAT.	СНАТ	PFIC		
- and	6 1	Love										MD. 20	852	
23. PART I. Enter the diseases, o	r complications the	it caused the de	eath. Do no										oximete	_
shock, or heert fellur	e. List only one cer	see on each line	в.								,	inter	vai Betv	veen
IMMEDIATE CAUSE (Finel disease or condition	(B)	1 00	1									Onse	and D	watn
resulting in death)	a. DUE TO	OR AS A CONSE	WCD OF		110	7						~	O	4
		(on no n oonoz										i		
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING	bDUE TO	(OR AS A CONSE	OUENCE OF):	:										
CAUSE (Disease or injury that initiated events	cDUE TO	(OR AS A CONSE	OUENCE OF):											

AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) 1 YES 2 NO NOSPITAL:
1 Inpetiant 2 - ER/Outpetient 3 - DOA OTHER: 4 Nursing Nome 5 Residence 6 Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 27. MANNER OF DEATH 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 5 Pending Investigation 1 YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 8 Could not be determined 4 Nomicide

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner se stated.

				\Rightarrow
A NAME AND ADDRESS OF I	SERCON WHO COMB	EYED CAUDE	Descript or William Co.	n Olive Duler
O CAN NO	Blank	tard	338	S N

D4320

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year)

24a. WAS AN AUTOPSY

31. DATE FILED (Morith, Day, Year) FFB 03 1995

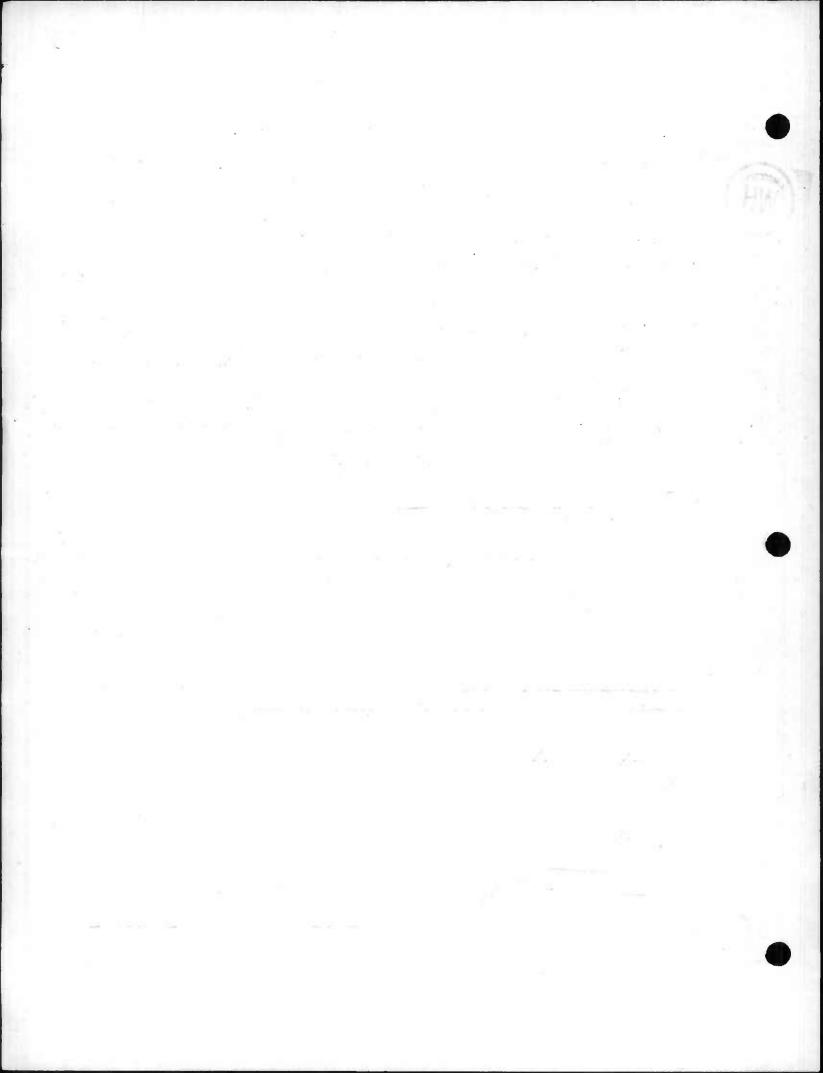
205 SIGNATURE AND TITLE

reaulting in death) LAST

320 BEGISTRAR'S FIGNATURE

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i.

DHMH-16 Rev 1/89



1	-	STATE REGISTR	AF
	1. D	ECEDENT'S	N.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICAE

	1 - STATE REGISTRAR	SIAIL OF I	CE				DEATH	MENIA	REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH									4			
		9					January 25, 1995			10:55	Рм		
FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. les						IF UNDER 24 HRS.	7. DATE OF BIRTH		0 BIRTHS	PI ACE (State or For	nian	
	578-40-2221	-2221 1 X M 2 □ F 68			RS. MONTHS DAYS HOURS			(Month, Day, Year) Sept.21, 1926		Country	Missour	i	
	9a. FACILITY NAME (If not institution, give stre	eet and number)			9b. CITY	r, TOWN (OR LOCATION OF D				NTY OF DE		
	Medbridge Nursing	g Home			Wheaton Montg						lontge	omery	
EC	10a, STATE 10b, COUNTY			10c. CIT	Y, TOWN (OR LOCAT	TION					10d, INSIDE CITY	
<u>=</u>	Maryland Mont	gomery			C	lney	7					LIMITS?	40
¥	10e. STREET AND NUMBER						. ZIP CODE			10g. CIT		HAT COUNTRY?	
ER	4029 Laytonsville	e Road					208	832			USA		- 4
5		12. WAS DECEDEN			13.	WAS DEC	ENDENT OF HISPA	NIC ORIGIN	? (Specify Yea	or No-	14. RACE	— American Indian	n,
BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE W	YES 2 NAR OR DATES	10			ecify Cuban, Maxica 2 X NO Specifi		Rican, etc.)			White, etc.	
	-		an War									noain	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of		(Gi	CEDENT'S	work done		ON st of working	16b	KIND OF BUS	SINESS/INI	DUSTRY		
)LE	Elementary/Secondary (0-12)	College (1-4 or 5+	·) ////////////////////////////////////	Do NOT us									
M	17. FATHER'S NAME (First, Middle, Last)			wai	ter				Restau				
E C	Ling Lee						18. MOTHER'S NA						
0	19a. INFORMANT'S NAME (Type/Print)		104	MAIL INC	ADDRES	S /Street o	DO1 nd Number or Rural		oy Qor		-		
5	Letitia Lee		1									D 0 00	
	20g, METHOD OF DISPOSITION		20b. PLACE				Apt. 30	DATI	W. Was	CATION	City or Tow	D.C. ZU	009
	1 X Burial 2 Cremation 3 Remov	ral from State	comptery crea	metary or a	ther placel		Park 1	1					. 1
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE	TIALKI	awii I	22.	NAME AN	ID ADDRESS OF FA	ICILITY				-	-
	* Imadella	400) . / 1				is J. Co						_
	23. PART I. Enter the diseases, or co	mallactions that	buch	ath O]]	00 L	niversit	ry BI	vd.W.	Sil.	Spr.		
	shock, or haart fallura. Li	at only one caus	se on aach ilna	ath. Do i	iot antar	tna mo	as or aying, suc	on an card	lac or respi	ratory ar	rest,	Approximat interval Bat	
	IMMEDIATE CAUSE (Final disease or condition	Channa	01 - +	- 4- 2	70	7	5.4					Onset and	
	resulting in death)					Imon	ary Dise	ease				10 Ye.	ars
_	DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):												
CAT	n siry, lesding to immediate course. Enter UNDERLYING												
Ē	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):												
	resulting in death) LAST												
0	PART II. Other significant conditions	contributing to	death but not re	esultina i	n the un	derlylne	CSUSA alvan In	Part I	24s. WAS AN	AUTODOV	1000	WEDE AUTODOX COM	20100
MEDICAL	Congestive Heart	counting	uid ui	idaliyiiiş	Cause given in	Part I.	PERFORMED?			WERE AUTOPSY FINI AVAILABLE PRIOR TO	0		
	1 □ YES 2 M NO COMPLETION DF CO									USE			
	DID TORACCO LISE CONTRIBUTE TO CALISE OF DEATH, VES WIND TO LINESPEAD TO												
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DESCRIPTION TO SEE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)												
SIC		HOSPITAL:			OŢHER	a:		7. n. 2511	- TANK				\dashv
Ξ	27. MANNER OF DEATH	28e. DATE OF	INJURY	28b. TIM		28c. INJ	5 Realdenca		(Specify)	I II IBY OC	CHRED		
	1 Natural 5 Pending	(Month, Da	ry, Year)		URY	WO	RK?	204. DE3	CRIBE HOW II	NONT OC	COMED		
ВУ	2 Accident Investigation 3 Suicida Could not be 26s. PLACE OF INJURY — At ho				M 1 YES 2 NO			281, LOC/	281. LOCATION (Street and Number or Rural Route Number.				-
COMPLETED	4 Homicide detarmined building, atc. (Specify) Suicide 8 Could not be detarmined building, atc. (Specify) Suicide 8 Could not be detarmined building, atc. (Specify)												
	29a. CERTIFIER 4 IV CERTIFICATION TO A STATE OF THE STATE												
M	29s. CERTIFIER 1 (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and pleca, and due to the causs(s) and manner as stated. 2 MEDICAL EXAMINER: On the best of axamination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(e) and manner as stated.												
	an conservine and disk of reference B												
BE	1/8/1/13	has	28c, LICENSE NUM							,			
2	30. HAME AND ADDRESS OF PERSON WHO	COMPLETED CAN	D01120					20	20 January 26,1			у 26,199	15
1		Walter E. Goozh, M.D. 2309 Shorefield Road Wheaton , Maryland 20902											
	31. DATE FILED (Month, Day, Year)	32. REGISTRAF	R'S SIGNATURE	11610	roac	ı Wil	eaton,	nary.	land Z	0902			\dashv
	JAN 31 1995	Juli As	wilson Range	1.11									j
		Man Man		MONEY.									

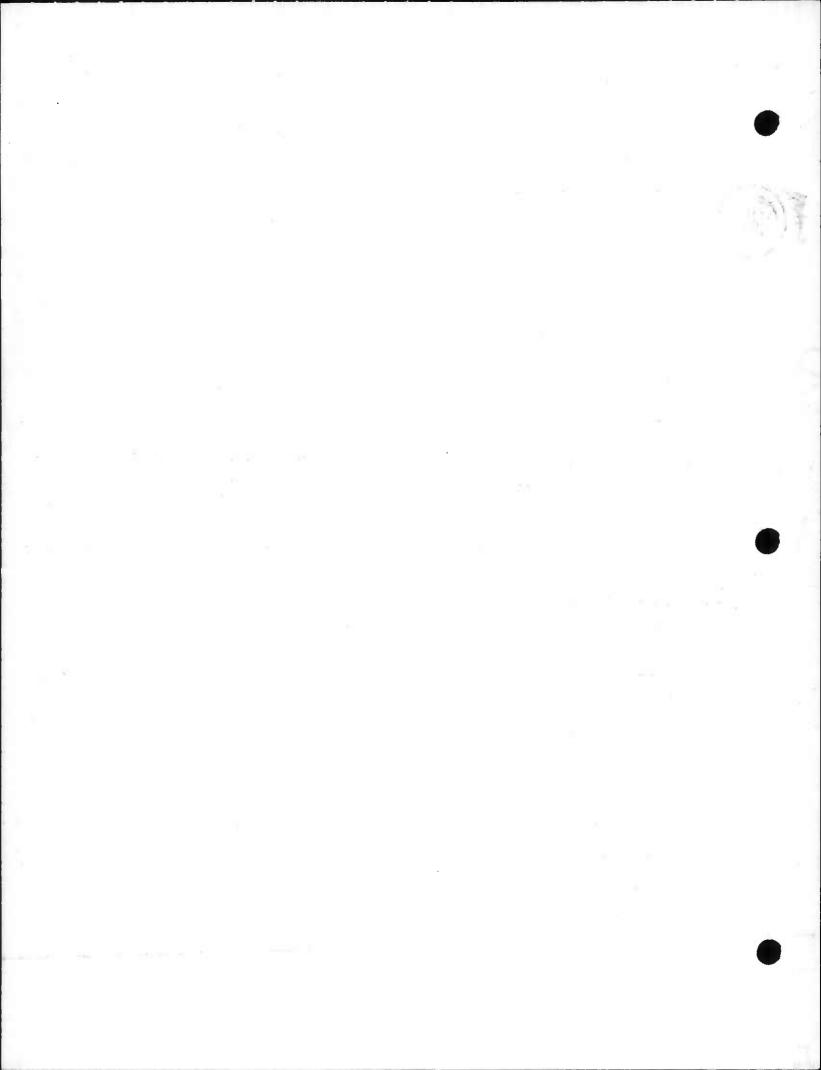
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transbe filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68769

BALTIMORE, MARYLAND 21215-0020

DHMH-16 Rev 1/89



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within's 5 hours after death. Page 6 may be retained by the hospital or amended TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: It item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

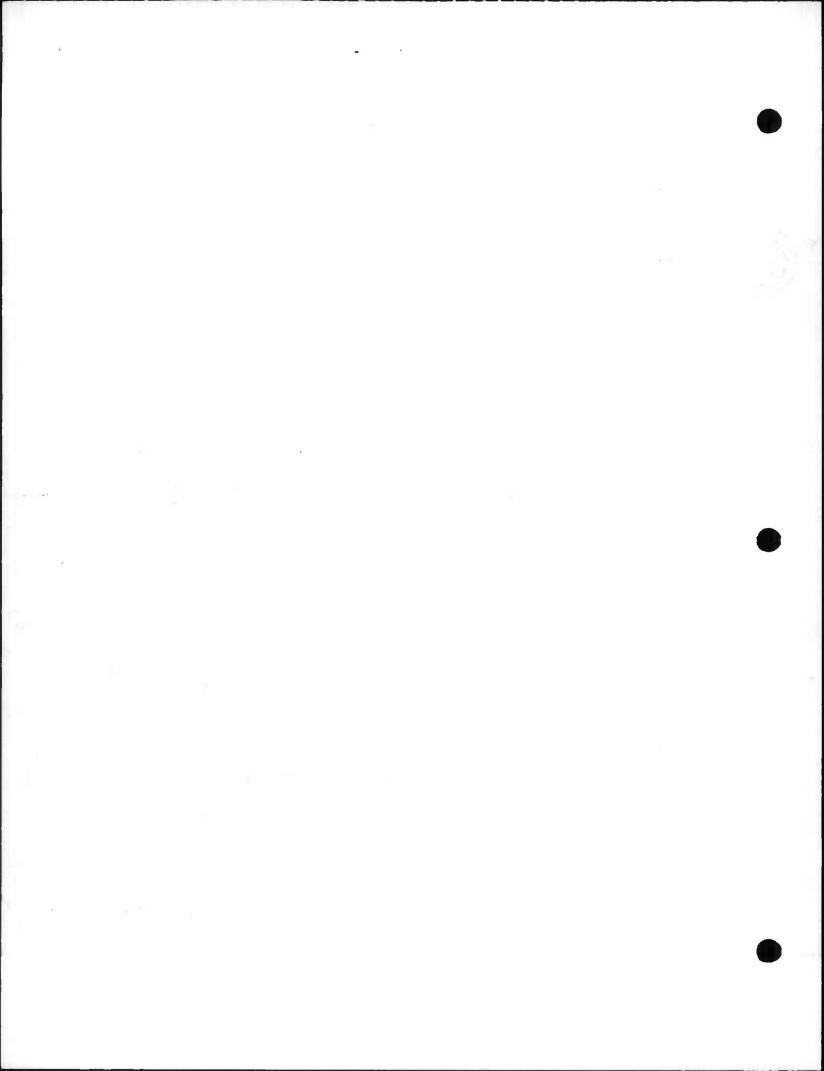
BALTIMORE, MARYLAND 21215-0

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCIENE

	1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO.												
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH MONTH DAY YEAR			VEAD	3. TIME OF DEATH	
		ynn		MURPHY					JAN.			995	8:45p M
		5. SEX	6. AGE (In yrs last		IF UNDER		YEAR IF UNDER 24 HRS. DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) NOV. 21,1952			8. BIRTH	PLACE (State or Foreign
DIRECTOR	101-42-2729	1 ☐ M 2XXF	42	YRS.	MONTHS			NOV. 21	, 1	952		SBURGH.PA.	
	9e. FACILITY NAME (If not institution, give stre				9b. CITY	TOWN O	R LOCATIO	ON OF DE	ATH		9c. COU	NTY OF D	EATH
	16801 NORWOOD RD.				SUSSEX MONTGOMER							1ERY	
EG	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN C	R LOCAT	ION	-		-		1	10d. INSIDE CITY
HIG	MARYLAND KE	NT		C	HESTI	ERTO	WN						LIMITS?
	10e. STREET AND NUMBER					101.	ZIP CODE			_	10g. CITI	IZEN OF W	THAT COUNTRY?
ER.	104 EAST CAMPUS A	VE.					216	520				USA	
FUNERAL		12. WAS DECEDENT FORCES? 1	T EVER IN U.S. ABA	AED	13.	WAS DECI	ENDENT O	F HISPAN	IC ORIGIN? (Specif	y Yes	or No-	14. RACE	— Americen Indien, , While, etc.
BY F	1 Never Merried 2 Merried 3 Wildowed 4 X Divorced	IF YES, GIVE W		0			2 NO		n, Puerlo Rican, ele	-)		Specif	v.
	15. DECEDENT'S EDUCA	TION	40 - 054		1								WHITE
E	(Specify only highest grade of	ompleted)	(Gh	ne kind of t	Work done of se retired.)	during mos	on st of workin	g	16b. KIND O	120			
PLE	Elementery/Secondary (0-12)	College (1-4 or 5+)		WITNE	ess o	COORI	TNA			OUNTY		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)								ME (First, Middle, M.		EY ^{tt} S	OFFI	UE
	PAUL R. RUSH								VIRGINI			HIE	
) BE	19e. INFORMANT'S NAME (Type/Print)		19b.	MAILING	ADDRESS	(Street ar			loute Number, City o				
2	SUSANNE HAYMAN		11	17 M	ANOR	AVE.	. CHE	ESTE	RTOWN, M	D.	2162	20	
	20e. METHOD OF DISPOSITION 1 ☐ Burlel 2XEXCremetion 3 ☐ Remov	oul from State	20b. PLACE A	ND DATE	OF DISPOS	ITION (Na	me of		DATE 20	c. LO	CATION —	City or To	wn, State
	4 Donetion 5 Other (Specify)		CAPT	ľAL (CREMA	TORY	Y JAI	N. 25	5,1995 D	ov	ER, I	DE.	
	21. SIGNATURE OF THERAL SERVICE LICE	MSEE / . 1/	,		22.	PFECT	LOWS	- WI	ELLS FUN	ER	AL HO	OME	
	Yary B.	tella	25			413	HIGH	I ST	. CHESTE	RT	OWN,	MD.	21620
	23. PART I. Enter the diseases, or co shock, or heart failure. Li	implications that	caused the dea	th. Do i	not enter	the mod	de of dyl	ng, such	ss cardiac or i	eap	ratory an	rest,	Approximate
	IMMEDIATE CAUSE (Final				,	,							Interval Between Onset and Dasth
	disease or condition reaulting in death)	Mu	this	- 6	An	1111	suis	1					
	disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentially list conditions, If any leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
Ä	If any, leading to immediate cause. Enter UNDERLYING												
틸	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):												
H	resulting in death) LAST												
	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									WEDE AUTOBOY CIMOIAGO			
S	Some services and some services and services are services and services and services are services and services and services are services and services and services are services and services and services are services and services and services are services and services and services are services and services are services and services are services and services are services and services are services and services are services and services are services and services are services and services are services and services are services and services are services are services and services are services and services are services and services are services are services and services are services and services are services are services are services and services						cauae g	PERFORM			MED?	240.	AMILABLE PRIOR TO COMPLETION OF CAUSE
	1 Yes 2 I NO OF								OF DEATH?				
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN												
AN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only One)												
Sic		HOSPITAL:	ER/Oulpatient 3	□ DOA	OTHER		5 🗆 Re	sidence	8 Other (Specify				
PHYSICIAN: MEDICAL	27. MANNER OF DEATH	28e. DATE OF		28b. TIM	E OF	28c. INJU	JRY AT		28d. DESCRIBE H		NJURY OC	CURED	
ВУ	1 Netural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation 1-22-95 1753 M 1 YES 2 NO motion rehicle accident									dent			
	3 Suicide 28e. PLACE OF INJURY — At home, Ierm, street, factory, office 28f. LOCATION (Street end Number or Rural Route Number,												
	4 Homicide determined Street Success, Mar. Stelle 16801 Norwood Rd Success, Mo.												
P	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated.												
COMPLETED	one) 2 MMEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and manner se stated.												
ш	29b. SIGNATORE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month), Da							(Month, Day, Year)					
0 8	Dennis for	Chate	m	O.C.M.E. ▶ JAN. 24/95									
일	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS											
	111 Penn Street, Baltimore, Maryland 21201												
JAN 30 95 Julia Davidson-Randola													
	July 0 33	I A	ina Dayds	n-Ra	ndose								



978WAShington

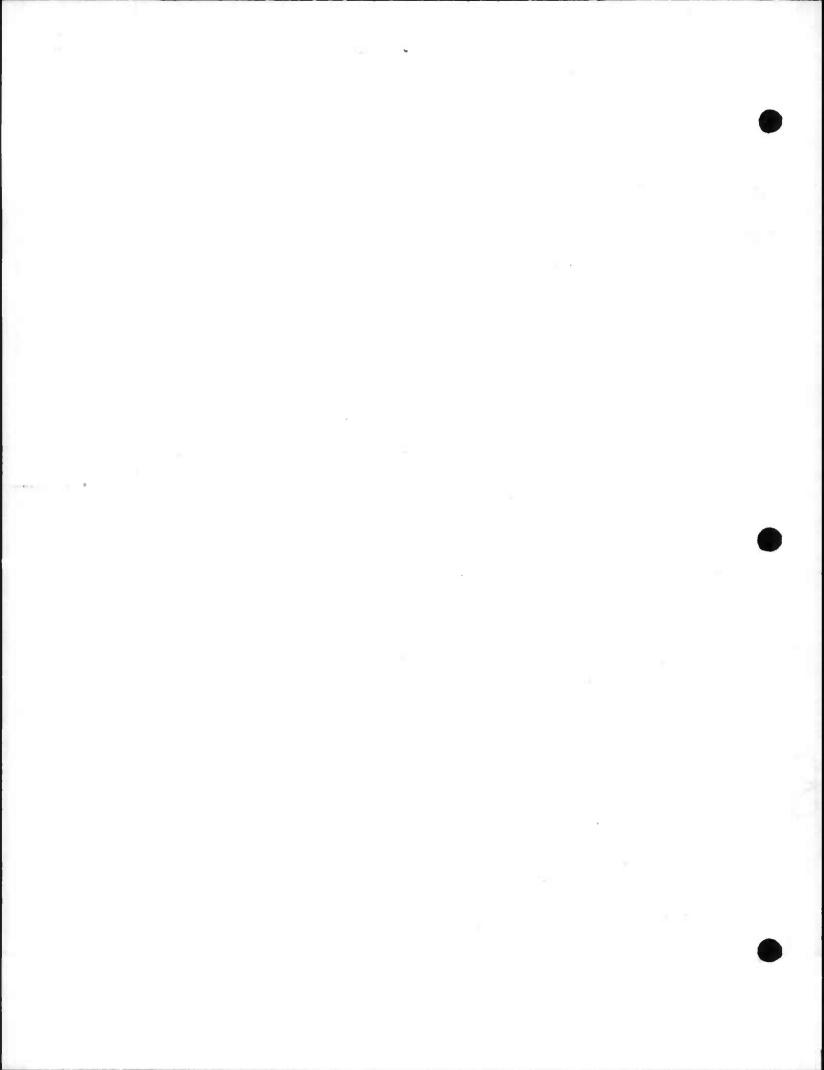
JAN 30 '95

DIVISION OF VITAL RECORDS, P.O. BOX 68/60, BALTIMORE, MARYLAND 21215-0020		
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	V	_
DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit perhours after death with the State Debt. of Health and Mental Hydiene prior to burial, cremanion, or removal.	The state of the s	ppp
item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.		

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Miller, Russell William Russell Miller 12:30 p. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH
(Month, Dey. Year)
NOV. 24, 8. BIRTHPLACE (State or Foreign 218 09 2111 1X M 2 D F HOURS DAYS 79 Maryland 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR Still Pond 26651 Maple Avenue Kent RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Kent Still Pond 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 26651 Maple Avenue 21667 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR OATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Mexicen, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Merried 2 Merried Specify: White BY 3 Widowed 4 X Divorced COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementery/Secondery (0-12) College (1-4 or 5+) Lawn Care Maintenance 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) William H. Miller Elizabeth Toulson BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Wayne Carter 23025 Old Fairlee Road, Chestertown, Maryland 21620 20e. METHOD OR DISPOSITION
1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Capitol Crematory 4 Donetion 5 Other (Specify) 1/26/95 Dover, Delaware 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Fellows-Wells Funeral Home Jary 413 High Street, Chestertown, Maryland 21620 23. PART I. Enter they seases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Approximata** shock, oy heart failure. List only one ceuse on each line. Intarvai Between IMMEDIATE CAUSE (Finei **Onaet and Death** diseese or condition DUE TO (OR AS A CONSEQUENCE OF) recuiting in death) Acute Mysesselisel Dufarcfine
DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially liet conditions, If eny, leading to Immediate ceuse. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reculting in deeth) LAST PART II. Other eignificent conditione contributing to deeth but not recuiting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL Recent Fratefue @ Fugurar pute 10 Barro COMPLETION OF CAUSE 1 | YES 2 | NO OF DEATH? Asuse, Barddine + CABILE Blood Pressure. 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Reeldence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DEŞCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO worre, BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE C- aunda 1/23/95 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 23889 2

Clusterfown Med 21420

32. REGISTAR'S SIGNATURE
Suha Day doon-Randale

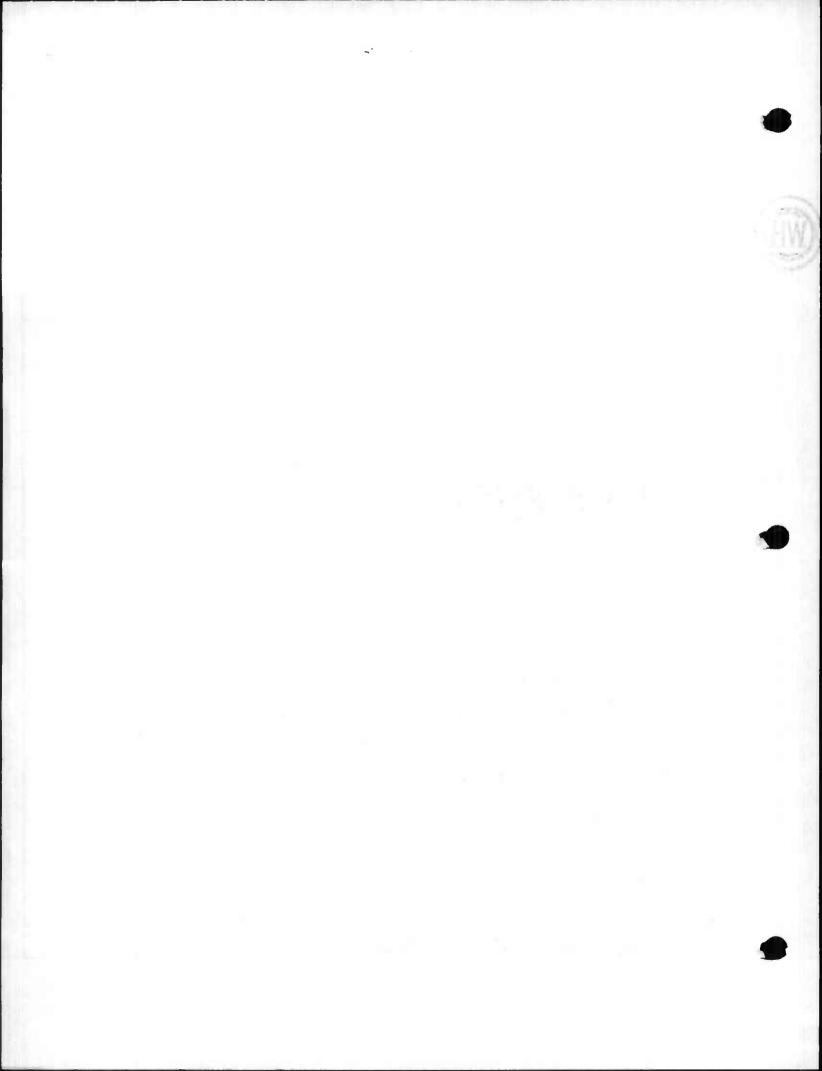


BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2. Mours after death, Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	3. TIME OF DEATH			
	Calvin Roe Merch	nant SR.			January 25, 1995 11:15P					
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	T DATE OF BURTH		MATERIAL AND ADDRESS OF THE PARTY OF THE PAR		
	221-14-9126	1 ⊠ M 2 □ F 7 5	YRS.	MONTHS DAYS	HOURS MIN.	Mar. 13, 1	919 M	aryland		
	9e. FACILITY NAME (If not institution, give street			9b. CITY, TOWN	OR LOCATION OF DE	ATH	9c. COUNTY	OF DEATH		
B	Magnolia Hall Nu	irsing Hor	ne		tertown		Kent	or serin		
DIRECTOR	RESIDENCE OF DECEDENT						Renc			
분	Maryland Kent			Y, TOWN OR LOC				10d. INSIDE CITY LIMITS?		
			RO	ck Hal	1			1 YES 2 NO		
FUNERAL	100. STREET AND NUMBER 22080 Herrington	n Darde Doe	. J		Of. ZIP CODE			OF WHAT COUNTRY?		
ÿ					21661		USA			
큔	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 TYPES	N U.S. ARMED	13. WAS DE	CENDENT OF HISPAN pecify Cuban, Mexican	IC ORIGIN? (Specify Yes	or No- 14.	RACE American Indian, Black, White, etc.		
В	3 Wildowed 4 Divorced	FORCES? 1 YES			S 2 NO Specify			Specify: White		
	15. DECEDENT'S EDUCA	unknown	16a. DECEDENT'S	HOUSE OCCUPAT	100					
COMPLETED	(Specify only highest grade co	ompleted)	(Give kind of the Do NOT up	work done during no se retired.)	iost of working	16b. KIND OF BUS	3INESS/INDUST	AV.		
7	Elementary/Secondary (0-12)	College (1-4 or 5+)	Truck 1			Constr	natio	m		
2	17. FATHER'S NAME (First, Middle, Lest)		TI den 1	DIIVEI	T 40 MOTUFOIO MAN	WE (First, Middle, Meiden		[]		
	Noah Merchant				May Ca		Surname)			
BE	19a. INFORMANT'S NAME (Type/Print)		10h MAII ING	ADDOESS (Street	-	loute Number, City or Town	0			
임	Ernest Merchant	_						all,MD.2166		
	20e. METHOD OF DISPOSITION	206	. PLACE AND DATE				CATION - City			
	1 🗵 Burial 2 🗆 Cremation 3 🗆 Remove 4 🗆 Donation 5 🗆 Other (Specify)	al from State Cen	netery, crematory or o	ther place)		1				
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE	estey (22. NAME	AND ADDRESS OF FAC	y1/27 Ro	ск на	LI,MD		
	* Kirk of	Well.	Pin			Funeral ck Hall,				
	23. PART (. Enter the diseases, or con	inplications that cause	d the death. Do r	not enter the m	ode of dving, such	as cardiac or read	ratory arrest.	Approximata		
	shock, or heart failure. List IMMEDIATE CAUSE (Fine)	it only one ceuee on e	ach lina.				,	interval Between		
ı	disease or condition	Caroli	Lulus		As den	<i>†</i>		Onsat and Death		
ŀ	resulting in death) DUE TO (OR AS A PONSEQUENCE OF):									
z	Chalonecocascinoma									
CERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):									
<u>8</u>	CAUSE (Disease or Injury									
片	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	F):						
E	resulting in death) LAST									
ا ر	PART II, Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
<u>8</u>	Registration of Owner Town Charlesoft to description of Charlesoft Town									
PHYSICIAN: MEDIC	M Chronic De	seno 141	30 lesa	1 trus	111	1 YES 2	□ NO	OF DEATH?		
≥	Hin Helestin	- Art CCO	2 1	111000	100	7		1 YES 2 NO		
¥	25. WAS CASE REFERRED TO MEDICAL	77030	- 07	28.1	LACE OF DEATH (Che	CK ONLY ONE)				
25		HOSPITAL:	netlant 3 DOA	OTHER:						
Ĕ∥	27. MANNER OF DEATH	28s. DATE OF INJURY	28b, TIM	E OF 28c. IN	JURY AT	28d. DESCRIBE HOW II	NJURY OCCURE	D.		
	1 Natural 5 Pending	(Month, Day, Year)	INJ	URY W	ORK? YES 2 NO	aca. acquinac iloni il	TOOM OCCORE			
D BY	2 Accident Investigation 3 Suicide 6 Could not be	28s. PLACE OF INJURY	— At home, farm, s		281 LOCATION (Street and Number or Burnt Boute Number					
	4 Homicide determined	building, etc. (Spec	261. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
۳	29a. CERTIFIER									
COMPLE	CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Cleck only one) 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	AND ROUNTIEF AND VITE OF ACCUSE									
BE	avales n		29d. DATE SIGNED (Month, Day,							
2	30. NAME AND ADDRESS OF PERSON WHD	COMPLETED CAUSE DE DE	ATH (ITEM 27) /See	Print)	- 0 7 8 0	/	- //.	25/95		
948 WAS hive In Ave Chesta form, Wed 21620 31. DATE FILED (MONTH), Day, Year) 32. REGISTRAR'S SIGNATURE										
	IAN 26 '05	Lilia No.	idson-Rand	00_						
		- CONTROLL	1-10-1							



DIVISION OF VITAL RECORDS, P.O. BOX 68769	BALTIMORE, MARYLAND 21215
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hourshill or attend	ifter death. Page 6 may be retained by the hospital or attent
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the find within 29 hours after death with the State han of Mantel Harings and to have a hour amount	r the funeral director, page 5 should be detached for use as
The med within 12 Hours are beat with the Case been, or regular and mental regiment bounds, contract, the medical examiner must be notified at once. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	cal examiner must be notified at once.

	FOR 1 • STATE REGISTRAR	STATE OF MARYL				EALTH AND	MENTAI		_			
	1. DECEDENT'S NAME (First, Middle, Last)	Α.	OLITTI	1	(11)	5 SR.	2. DATE	OF DEATH	. 0a	YEAR 3.	TIME OF DEATH	. M
	4. SOCIAL SECURITY NUMBER 579-03-2742 9a. FACILITY NAME (If not institution, give s	1)(XM 2 □ F 80	In yrs. last birthday,	MONTHS	DAYS	IF UNDER 24 HRS. HOURS MIN.	ctob	of Birth Day, Year) er 2,	1914	Mary		
TOR	Shady Grove Adver		1	96. COUNTY OF DEATH ROCkville Montgomery								
DIRECTOR	Maryland Frede	•		TY, TOWN O		TION				100	d. INSIDE CITY LIMITS? YES 2 NO	
FUNERAL	8131 Old Kiln Roa					21788			Unite		tes	
BY	11, MARITAL STATUS 1 Never Merried 2V Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, OIVE WAR OR DA	2 X NO		If yes, sp	CENDENT OF HISPAI ecify Cuban, Maxica 2 NO Specif	an, Puarto F	? (Specify Yei Noan, etc.)	s or No— 1	4. RACE — Black, W Specify:	American Indian, Thita, atc. White	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION o completed) College (1-4 or 5+)	16a. DECEDENT (Give kind of life. Do NOT	work done use retired.)	CCUPATIO	ON sst of working		echani	SINESS/INDU	STRY		
BE COM	17. FATHER'S NAME (First, Middle, Last) Clarence E. Mills	5	CONTENT	3001		18. MOTHER'S NA	ME (First, A					_
10	Hazel H. Mills					Road, Th					1788	
	20a. METHOD OF DISPOSITION 1	FO FO	PLACE AND DATE etery, cremetory or rest Oal	other place) K Cem	eter	^V	2/6		cation – ci thers b		Maryland	
	21, SIONATURE OF FUNERAL SERVICE LIC	H. Bar	her	Mu	riel	H. Bart	ber F	uneral	l Home	1	20882 ille, Md.	Ī
	23. PART i. Enter the diseases, or a shock, or heart fellure.	complications that caused List only one cause on e	the daeth. Do	npt anter	tha mo	de of dying, auc	h as card	iec Dr reepi	ratory arre	nt,	Approximata Interval Betwee	en.
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. multiply	CONSEQUENCE	in `	fai	lure			-		36 ms	ih.
NOI	Sequentially list conditions,	b. GVEVUL DUE TO (OR AS A	relmin CONSEQUENCE	1 G	se	psis					72 hrs	5.
CERTIFICATION	cause. Entar UNDERLYING CAUSE (Discess or Injury that initiated events resulting in deeth) LAST	a towel of DUE TO (OR AS A	CONSEQUENCE O	tion	7 0	und pe	rfe	vati	m		10 days	5
CER								on Co	ance	*		
DICAL	PART II. Other algorificent condition	a contributing to death b	ut not resulting	in tha un	deriyin	g ceuse given in	Part i.	24a. WAS AN PERFOR	RMED?	CO	RE AUTOPSY FINDINGS VILABLE PRIOR TO MPLETION OF CAUSE DEATH?	3
PHYSICIAN: MEDICAL	DID TOBACCO USE CONT		F DEATH Y			UNCERTAI	N 🗆			1 {	YES 2 NO	
SICI	EXAMINER?	HOSPITAL:		OTHER	₹:	e 5 🗆 Raaldence	6 Other	(Specify)				_
BY PHY	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28c. INJ W0 1 🔲 '	URY AT PRICE 2 NO			NJURY OCCU	RED				
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm,	street, fact	ory, offic			TION (Street a or Town, State)	and Number of	Rural Route	Number,	
COMPLET		ICIAN: To the best of my knowl IR: On the basis of exemination									d manner as stated.	
TO BE (296. SIGNATURE AND TITLE OF CERTIFIER	wh				29c. LICENSE NUM D 2 4 7		MD	- 1		onth, Day, Year)	-
C 18	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DEA	ATM STEM 27 /S-	n Deimth								_

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Rolart L. Fox, M.D. 9715 Medical

2X M.D. 9

1 32. REGISTRAR'S SIGNATURE

1 A MUNICIPAL PARAGE

Robert U 31. DATE FILED Month, Day, Year) FFB 1 1995

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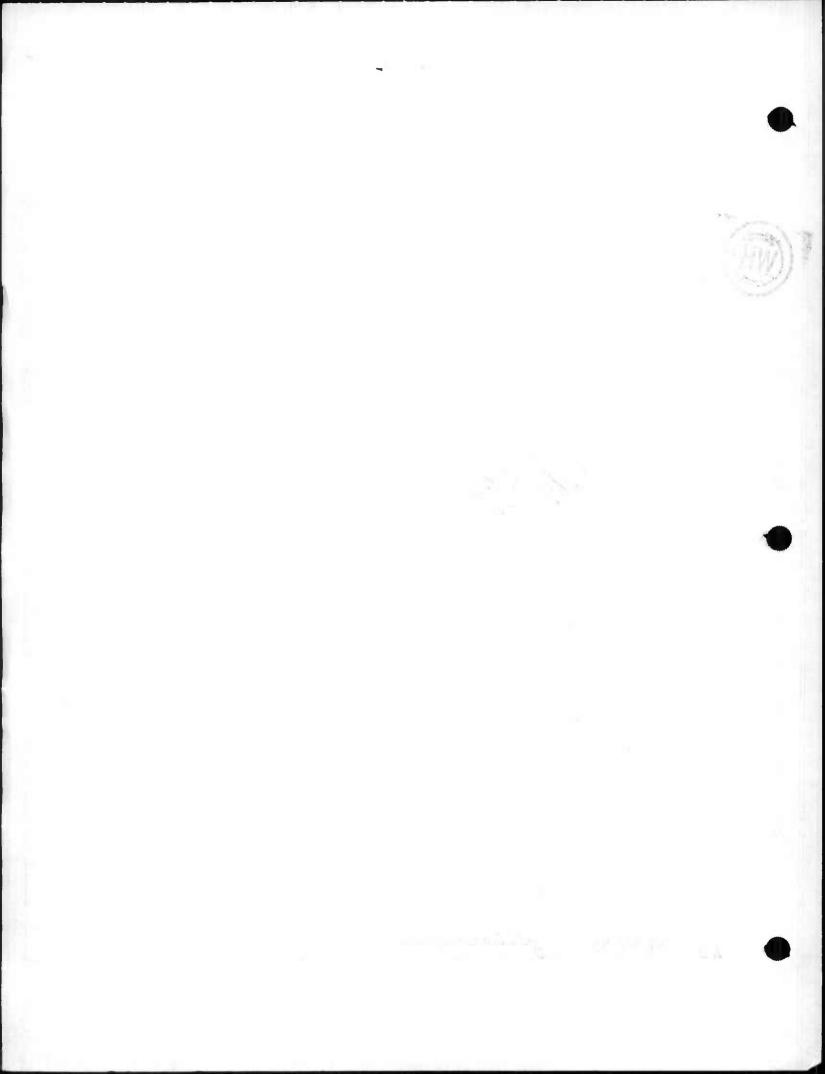
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ì	1. D	ECEDENT'S

1, 2, 3 should

	1 - STATE REGISTRAR	SIAIL OF R	CE	RTIF	ICATE OF	DEAT	H		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF	DEATH		VEAD	3. TIME OF DEATH	
	Phyllis Ann Miller							Janu	ary J	l'2, 1	1995	1315 hrsm	
		5. SEX	6. AGE (In yrs. lesi	200	IF UNDER 1 YEAR	IF UNDER 2	24 HRS.	7. DATE OF (Month, D	lany, Year)		Country	PLACE (State or Foreign	
	Z13 34 0014	1 □ M 2 😾 F	56	YRS.				April	6, 19	938	Mar	yland	
œ	9a. FACILITY NAME (If not institution, give stre				96. CITY, TOWN					9c. COI	JNTY OF D		
ō	Magnolia Hall Nur	sing Ho	me		Chestertown Ken							t	
띭	10a. STATE 10b. COUNTY			10c. CITY, TOWN OR LOCATION Chestertown								10d, INSIDE CITY	
ā	Maryland Queen	Annes				este	rtown				LIMITS?		
AL	10a. STREET AND NUMBER			101. ZIP CODE								HAT COUNTRY?	
FUNERAL DIRECTOR	101 Concord Road					21620	U			tates			
쿤	11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2			MED	13. WAS DEC	ENDENT OF	HISPANI	C ORIGIN? (Specify Yea or No— 14. RACE — Ame Black, White,				- American Indian, White, etc.	
84	3 Wildowed 4 Divorced	IF YES, GIVE W	MR OR DATES				Specify:		10.00		Specify: White		
	15. DECEDENT'S EDUCA		16a. DE	CEDENT'S	USUAL OCCUPATI	ON		16b. KI	ND OF BUS	SINESS/IN		е	
	(Specify only highest grade co	mpleted) College (1-4 or 5 -		ve kind of Do NOT u	work done during mo se retired.)	si of working	7						
를	12		C1	erk					Groce	ery			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTNE	ER'S NAM	AE (First, Mide	de, Maiden	Sumame)			
BE	Elmer J. Huber Sr.							Hurle					
2	19a. INFORMANT'S NAME (Type/Print)		1		ADDRESS (Street)								
	Mrs. Helen Herman				oncord Reposition (N		Ches		-			21620	
	204. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remove 4 Densition 5 Other (Specify)	al from State	cometery, crer	natory or o	etery - J	ime or	16	DATE			Maryla		
ı	21. SIGNATURE OF FUNERAL SERVICE LICES	her U	Va.diip.to	7					CLUII	uii, i	LEILYIC	· ·	
	22. NAME AND ADDRESS OF FACILITY Fellows Funeral Homes, P.A. 370 Cypress Street, Millington, Maryland												
	23. PART I. Enter the diseases, or con		t caused the de-	eth Do	370 C	press	Stre	et. Mil	lingt	on, M	arylan		
	shock, or haert failure. Lis	at only one cau	se on each line.		not enter the me	de oi uyiii	ig, such	i as cerdiec	or respi	ratory e	reat,	Approximate interval Between	
	iMMEDIATE CAUSE (Finel disease or condition	SEPSIS										Onset and Death	
	resulting in death) a.,			UENCE O	F):							Ldays	
z	DE TO (OR AS A CONSEQUENCE OF): DECUBITUS ULCEN Week												
6 E	Sequentielly list conditions, If any, leading to immediate												
2	CHOSE (Disease of finjuly											> Lyear	
CERTIFICATION	that initieted events resulting in death) LAST	MULT	LPUS CE	G CENTRIN VALUATE ACCIDENTS							5 wears		
	PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PINDINGS												
DICAL				sulting	in the underlyin	g ceuse gi	ven in P	Part I. 24	a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO	
ğ	INCONTROLLET							_ •	YES 2	KNO		COMPLETION OF CAUSE OF DEATH?	
ME	MULTIMPARC	pen	1ENTIA									1 YES 2 NO	
AN	CONGESTIVE 18 25. WAS CASE REFERRED TO MEDICAL	EMIT F	111111111	>									
PHYSICIAN:	EXAMINER?	IOSPITAL:			OTHER:	ACE OF DE							
H	27. MANNER OF DEATH	28a. DATE OF	ER/Outpatient 3 INJURY	28b. TIM	4 Nursing Nor	e 5 ☐ Resi	7	28d, DESCRI		LIIIDV OC	CIBED		
	Netural 5 Pending Investigation	(Month, Di	ay, Year)		JURY WO	RK7	- 1	Lou. DECOM	DE NON N	vooni oc	CORED		
9 8 ₹	2 Accident investigation 3 Suicide 8 Could not be	28a. PLACE O	F INJURY — At hor	ne, term, a	street, factory, offic	•		281. LOCATIO		nd Numbe	r or Rural A	oute Number,	
Ē	4 Homicide determined	aunamy,	etc. (Specify)					City or Ti	own, State)				
1 1	29a. CERTIFIER (Check only 1 CERTIFYING PNYSICIAL	N: To the best of	my knowledge, des	ith occurr	ed at the time, date	and place, e	end due t	to the cause(e) and man	ner as sta	rted.		
COMPLETED	one) 2 MEDICAL EXAMINER:											and manner ea stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER											(Month, Day, Year)	
a Maria Maria										1-1-	1-95		
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	SE OF DEATH (ITEM	1 27) (Type,	, Print)			-			, , ,		
الدر	JAN 40 95	Juna Dav	R'S SIGNATURE	lace.									
// III													

BALTIMORE, MARYLAND 21215-002 TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending my TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

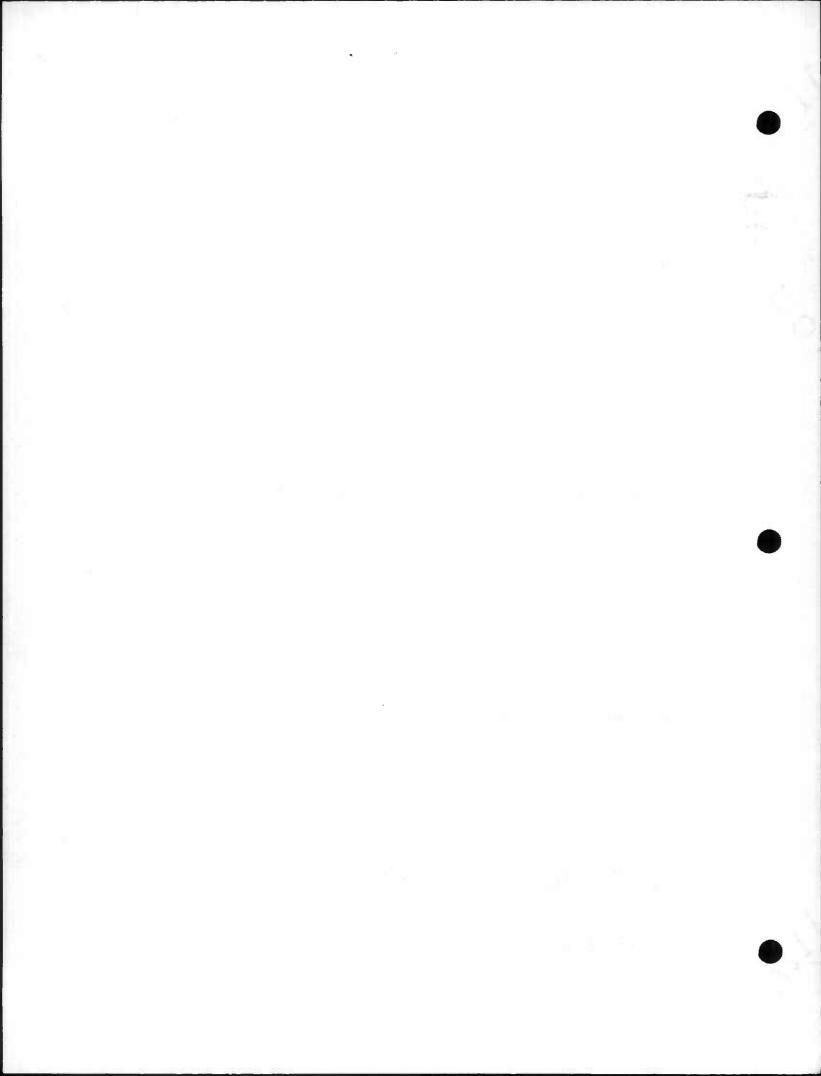


THOO SE OF	TO BE COMBI ETED BY BUYCICIAN, MEDICAL OFFICIATION
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
he funeral director, page 5 should be detached al.	TO THE FUNERAL DIRECTOR: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
ir death. Page 6 may be retained by the hosp	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withh. To hours after death. Page 6 may be retained by the hosp
BALLIMORE, MARTLAND	DIVISION OF VITAL RECORDS, F.O. BOX 88780

	1 - STATE REGISTRAR	STATE OF M			RTMENT OF			MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)	ERMAN	CLYDE					2. DATE OF DEATH MONTH	MY YE	3. TIME OF DEATH		
		L KPIAN	6. AGE (In yrs. les		LLLER			01 3		5 12:05 PM		
			8.4	YRS.	MONTHS DAY		R 24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) 01-06-191	9	BIRTHPLACE (State or Foreign Country) WV		
1 1	9e. FACILITY NAME (If not institution, give stree	**	04		9b. CITY, TOW	N OR LOCAT	ION OF D					
<u>بر</u>	Goodwill Menon		me		Grant			SAIT!	Garr			
[5]	RESIDENCE OF DECEDENT	100 110										
DIRECTOR	10e. STATE 10b. COUNTY				Y, TOWN OR LO					10d. INSIDE CITY LIMITS?		
	MD Garre	tt		Gra	antsvi	101, ZIP COL	26		Tan- OFFICE	1 ☐ YES 2 🙀 NO OF WHAT COUNTRY?		
FUNERAL					1		536		2.16			
S I	PO Box 310 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED				13. WAS			NIC ORIGIN? (Specify Ye	US.	RACE - American Indian		
	1 Never Married 2 Merried	FORCES? 1	YES 2 TA	10	If yes		an, Maxica	an, Puerto Ricen, atc.)		Black, White, etc. Specify: White		
УВ С	3 Widowed 4 Divorced									WIII		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor		(G	CEDENT'S ive kind of Do NOT u	Work done during	TION most of work	ing	16b. KIND OF BU	SINESS/INDUST	TRY		
🖫	Elementery/Secondary (0-12)	College (1-4 or 5+)	Farn	,			Acres				
N	17. FATHER'S NAME (First, Middle, Last)			rall	ier	18. MO1	THER'S NA	AME (First, Middle, Maiden	ultur	е		
U U	Charles Miller					C-0.00		le Jenkin				
00	19e. INFORMANT'S NAME (Type/Print)	-	191	b. MAILING	ADDRESS (Stre			Route Number, City or Tov		(e)		
입	Larry May			HC 3	30, Bo	x 401	M, A	Arthur, W	V 268	16		
	20a. METHOD OF DISPOSITION 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Remove	I from State	20b. PLACE	AND DATE	OF DISPOSITION	(Name of		OATE 20c. LC	CATION — City	or Town, State		
	4 Donation 5 Dother (Specify)		Cent	enar	y Cem	eter	У	2-2-95 I	Bruceto	n Mills, WV		
	21. SIGNATURE OF FUNERAL SERVICE LICEN Orthur H.		lt		Carl		pear	Funeral H		77. 26525		
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
	ahock, or heart fallure. List only one cause on each line.											
[]	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Congestive Heart Fa; Luce Onset and Death											
	a	DUE TO	OD AC A COMOCO	OUENCE O	7: /	,	0					
N N	Atheroselerotic Vascular Disiase											
CERTIFICATION	if any, laading to immediate											
윤	CAUSE (Disease or Injury CAUSE (Disease or Injury That Initiated events DUE TO (OR AS A CONSEQUENCE OF):											
	reaulting in death) LAST											
2	PART II. Other significant conditions of	contributing to	death but not a	- culting	In the Andrea	dwa wansi		Post las unas				
8	Cerebro vas cu	//	A C C	esulting	in the inden	ing cause	given in	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE		
	COCOTOVASCO	200	.,	100	7 6 -			1 _ YES :	2 1 NO	OF DEATH?		
Σ	DID TOBACCO USE CO	NTRIBLITE	TO CAUS	E OF	DEATH	YES [1 NC	াব		1 TYES 2 NO		
SICIAN:	25. WAS CASE REFERRED TO MEDICAL	711110112	TO CAUC) <u>.</u> 0.			4	heck only one)				
Sic		OSPITAL:	ER/Outpatient 3	□ DOA	OTHER:	lome 5 🗆 F	Residence	6 Other (Specify)				
PHY	27. MANNER OF OEATH	28e. DATE OF (Month, Da	INJURY	28b. TIN		INJURY AT WORK?		28d. DESCRIBE HOW	INJURY OCCUR	ED		
ВУ	1 Natural 5 Pending 2 Accident frivestigation					YES 2	□ NO					
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE Of building, i	F INJURY — At ho atc. (Specify)	me, farm,	atreet, fectory, c	ffica		281. LOCATION (Street City or Town, Stete		Burai Route Number,		
ETE					==							
AP.								n fo the cause(e) end ma				
COMPLET	2 MEDICAL EXAMINER:	On the beele of ex	amination end/or	investigatio	on, in my opinio	i, death occi	ured at the	time, date end placa, a	nd due to the ce	puse(e) end manner ee stated.		
BE (296. SIGNATURE AND TITLE OF CERTIFIER	18	00	/	nD	29c. LIC	CENSE NU	MBER	1	GNED (Month, Day, Year)		
2	30, MANY AND ADDRESS OF PERSON WHO C	OMPLETED CAUS	E OF DEATH ATT			ID	340	079	01-	31-95		
	dames E.	13e,'-	tzel	m D		Fra	nts.	wille n	الم الم	21536		
	31. OATE FILED (Month, Day, Year) FEB - 3 1995	32. REGISTRAI	R'S SIGNATURE	-						4		
	FEB - 3 1995	This offers	Low Rail	al T								

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-se hours after death. Plage 6 may be mainined by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me human director, page 5 shows the detector		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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2	6	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or renormal.	W

	- STATE REGISTRAR		CE	RTIF	CATE	OF	DEATH		RE	G. NO).					
	1. DECEDENT'S NAME (First, Middle, Last)								E OF D	EATH			3. TIME OF DEA	TH		
- 1	JAMES ALVIN ME	TZ						MON F	EB.	8,	1995	YEAR	1:25 A M			
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. last	last birthday) # UNDER 1 YEAR # UNDER 24 HRS. 7					7. DATE OF BIRTH 8. BIRTHP							
							16ar)	1908 PENNA.								
اء	9a. FACILITY NAME (If not institution, give street and number) GARRETT COUNTY MEMORIAL HOSPITAL					D. CITY, TOWN OR LOCATION OF DEA				ATH 9c. COUNTY OF DEATH GARRETT						
2	RESIDENCE OF DECEDENT	EMORIAL HO	SPITAL		UA	VL	עאו				GE	INKEI	. 1			
10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION										10d. INSIDE CITY LIMITS?						
- 1		. LAK	LAKE PARK						NO							
FUNEHAL	104. STREET AND NUMBER 400 "E" STREET					101. ZIP CODE 21550					10g. CITIZEN OF WHAT COUNTRY? USA					
5	11. MARITAL STATUS	12. WAS DECEDENT EV						NIC ORIGIN? (Specify Yee or No.— 14. R.					ACE — American Indian,			
ā	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1	OR DATES	0			cify Cuben, Maxica 2X NO Specif		Puerto Ricen, etc.) Black, White Specify:							
2	15. DECEDENT'S EDU (Specify only highest grade	16a. DEC	EDENT'S	USUAL OCC	UPATIO	N et of working	16	Sb. KIND	OF BU	SINESS/IN	DUSTRY					
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Me.	(Give kind of work done during most of working life. Do NOT use retired.) MINER					COAL							
Š	17. FATHER'S NAME (First, Middle, Last)		****			1	18. MOTHER'S NA				Sumamal					
BEC	HOWARD	METZ					CORA		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		SWEIT	CZER				
5	19+. INFORMANT'S NAME (Type/Print)						nd Number or Rural I		mber, Ci	ty or Tov	yn, State, Zij	p Code)				
1	JUDY WALKER			_			FALLS RD	_					21550			
	20a. METHOD OF DISPOSITION 1.A. Burlet 2 Cremetion 3 Rem 4 Donetion 5 Other (Specify)	oval from State	CARRE				GARDENS	1	10		CATION — KLANI		NARYLAND			
- 1	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22. NA	AME AN	D ADDRESS OF FA	CILITY		P	.O. I	3OX 2	243			
	folint 40	June	M0016	7	DU	RSI	FUNERAI	L HO	ME	- 0	AKLAN	AND, MD. 21550				
	23. PART I. Enter the diseases, or shock, or haart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that ce List only one cause of a. Congest	on each line.				de of dyling, auc	h as ca	rdiac d	or reap	Iratory ar	rest,	Approximinterval B Onset and 3 day	etween d Death		
	•		AS A CONSEO													
5	Sequentially list conditions,		clerot			vas	cular di	isea	se				3 yea	rs		
3	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	c.		5.5145F F41									į			
HILICATION	that initiated eventa resulting in death) LAST	DUE TO (OR	AS A CONSEO	UENCE OF):											
5	resulting in death) CAST	d												-		
AL (PART II. Other significant condition		ith but not re	sulting li	n the unde	erlyIng	cause given in	Part I. 24a. WAS AN AUTOPSY PERFORMED?				24b	24b. WERE AUTOPSY FINDINGS			
<u>}</u>	diabetes mellitu	S									NO		AWAILABLE PRIOR COMPLETION OF DEATH?			
Į.													1 YES 2	NO		
PHTSICIAN: ME	DID TOBACCO USE	CONTRIBUTE '	TO CAUS	SE OF	DEATI											
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER:	26. PL	ACE OF DEATH (Ch	eck only	one)							
2	1 VES 2 X NO	1X Inpatient 2 ER		DOA 28b. TIME	T .	e Homi	5 Reeldence			**	INJURY OC	CUREO				
	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Y		ILVI	JRY	WOI	ES 2 NO	200. 0	EŞUNIB	EHOW	INJUNY OC	COMED				
- 16	2 Accident Investigation 3 Sulcide 8 Could not be	28e, PLACE OF IN building, etc.	JURY — At hon	ne, farm, si	treet, factory	y, office			CATION by or Tow			r or Rural i	Route Number,			
	4 Homicide determined		(opcony)					Cit	y 01 10W	rii, State	,					
COMPLEIED	29a. CERTIFIER (Check only one) 1 \(\times \) CERTIFYING PHYSI (Check only one) 2 \(\times \) MEDICAL EXAMINE												e) and menous co	stated		
	296. SIGNATURE AND JITLE OF CENTIFIES								to ond j	, , ,						
	willer			VID)		296. LICENSE NUI D25759	-men					(Month, Day, Year)			
2	10. HAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE O	F DEATH (ITEM	27) (Type,	Print)		DE3133				1,16	brua	ту о, 1	77)		
	Walter K. Naumann	, M.D., PO	Box 2			den	t MD 215	520-	024	7						
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE	Lap												
	FEB - 8 1995	Maria and	ARY AND	Chief												



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KEC	requires that the de
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4	The
7	PHYSICIAN:
VISION OF VITAL RECORDS, P.O. BOX 68/60	I ATTENDING PHYSICIAN: T

296. SIGNATURE AND TITLE OF CERTIFIEB

20

31. DATE FILED (Month, Day, Year)

JAN

AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Lesin

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42. REGISTRAR'S SIGNATURE

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TIMORE, MARYLAND 21215-0020

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S HAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR ALEK Willard Hov 1353 1995 January 4. SOCIAL SECURITY HUMBER BIRTHPLACE (State or Foreign Country) B. AGE (in yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 6/18/15 IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 1 M 2 | F 577-16-2631 79 YRS. WV 9a. FACILITY HAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY oc. COUNTY OF PEATITO PENINSULA REGIONAL MEDICAL CENTER DIRECTOR RESIDENCE OF DECEDENT 10a. STATE MD 10c. CITY, TOWN OR LOCATION Berlin 10b. COUNTY 10d. IHSIDE CITY Worcester 1 YES 2 1 HO FUNERAL 10a. STREET AND HUMBER 10f. ZIP CODE 10g. CITIZEH OF WHAT COUNTRY? 2523 Ocean Pines 6 Windjammer RD burial-transit 21811 USA Page 6 may be retained by the hospital or attending physician 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 HO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Ho-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married yes, specify Cuban, Mexican, Puerto Rican, etc.) BY 1 YES 2 NO Specify: Specify: white 3 Widowed 4 ☐ Divorced funeral director, page 5 should be detached for use as the COMPLETED 15. DECEDENT'S EDUCATION
(Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATIOH (Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) **Fireman** Fire Fighting 17. FATHER'S HAME (First, Middle, Last) 18. MOTHER'S HAME (First, Middle, Maiden Surname) Asa Maier notified at Dehlia Young 8 19e. INFORMANT'S HAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Beverly Brown Maier 2523 Ocean Pines Berlin, MD be 20a. METHOD OF DISPOSITIOH

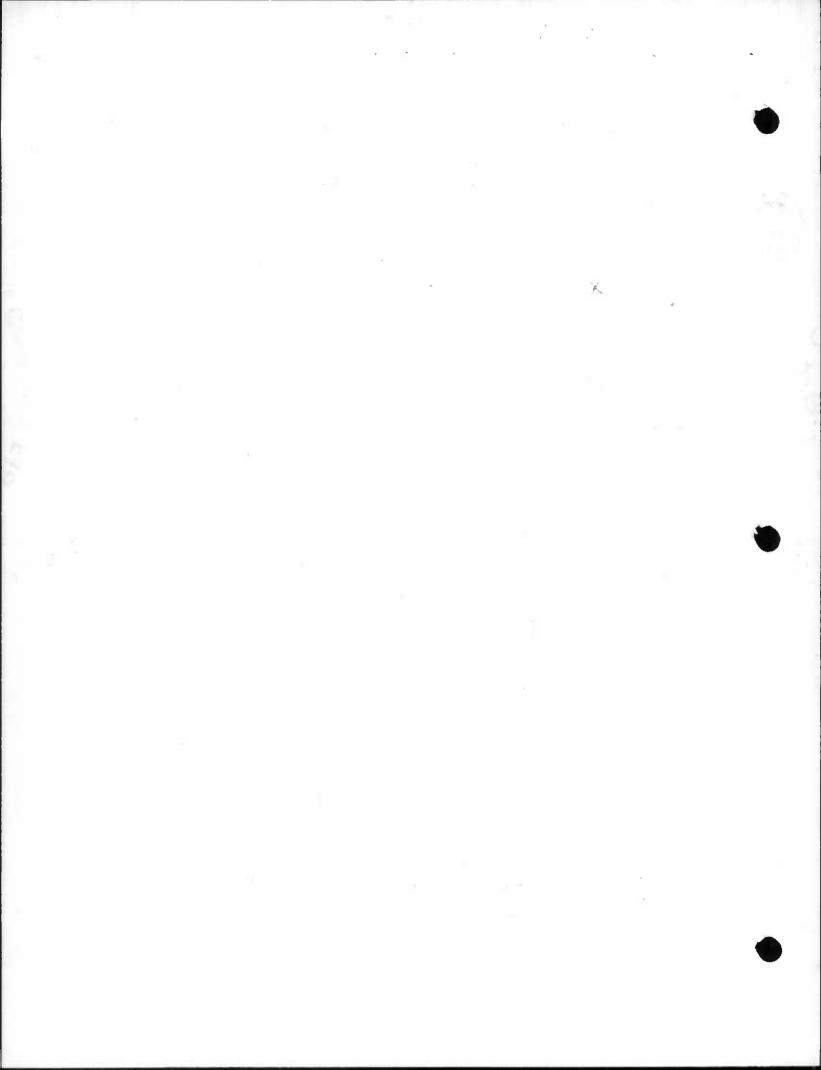
1 M Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATIOH - City or Town, Stata must Cedar Hill Cemetery 4 Donation 5 Other (Specify) 1/23/95 Suitland, MD examiner 22. NAME AND AODRESS OF FACILITY Burbage Funeral Home 21. SIGNATURE OF SONERAY SERVICE LICENSEE 108 Williams St. Berlin, MD medicai 23. PART I. Enter the Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardisc or reapiratory arrast, shock, or haert failure. List only one cause on each lina. in by Approximate interval Between ŏ filled IMMEDIATE CAUSE (Fine) Onset and Peath the cremation, eld disease or condition_ and completely fit burial, cremation DUE TO (OR AS A CONSEQUE other traumatic event, resulting in death) DUE TO (OR AS A COASEQUENCE OF): CERTIFICATION Sequentially list conditions, 9 if any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to Mers Ocko Dye 30 (OR AS A CONSEQUENCE OF): acker CAUSE (Disease or Injury that initiated events resulting in death) LAST 6 shows any injury, PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FIHDINGS MEDICAL signed by the AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | NO OF DEATH? en 1 YES 2 - HO of of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Hem certificate h OTHER: 1 YES 2 HO Mipstient 2 - ER/Outpatient 3 - DOA 4 Hursing Home 5 Residence 6 Other (Specify) 6 27. MAHNER OF DEATH 28a, DATE OF INJURY 28c. IHJURY AT WORK?

1 YES 2 NO 28b. TIME OF this c 28d. DESCRIBE HOW INJURY OCCURED is marked, INJURY 1. Natural 5 Pending 84 BY After 2 Accident Investigation 26s. PLACE OF IHJURY --- At home, farm, street, factory, office 3 Suicide 281. LOCATIOH (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be DIRECTOR: / 4 Homicide 28 29a, CERTIFIER 1 DEMTFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piace, and due to the cause(a) and manner as stated. HOSPITAL FUNERAL I within 72 h 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: B

29c. LICENSE HUMBER

02020

29d. DATE SIGNED Month, Day, Year)



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

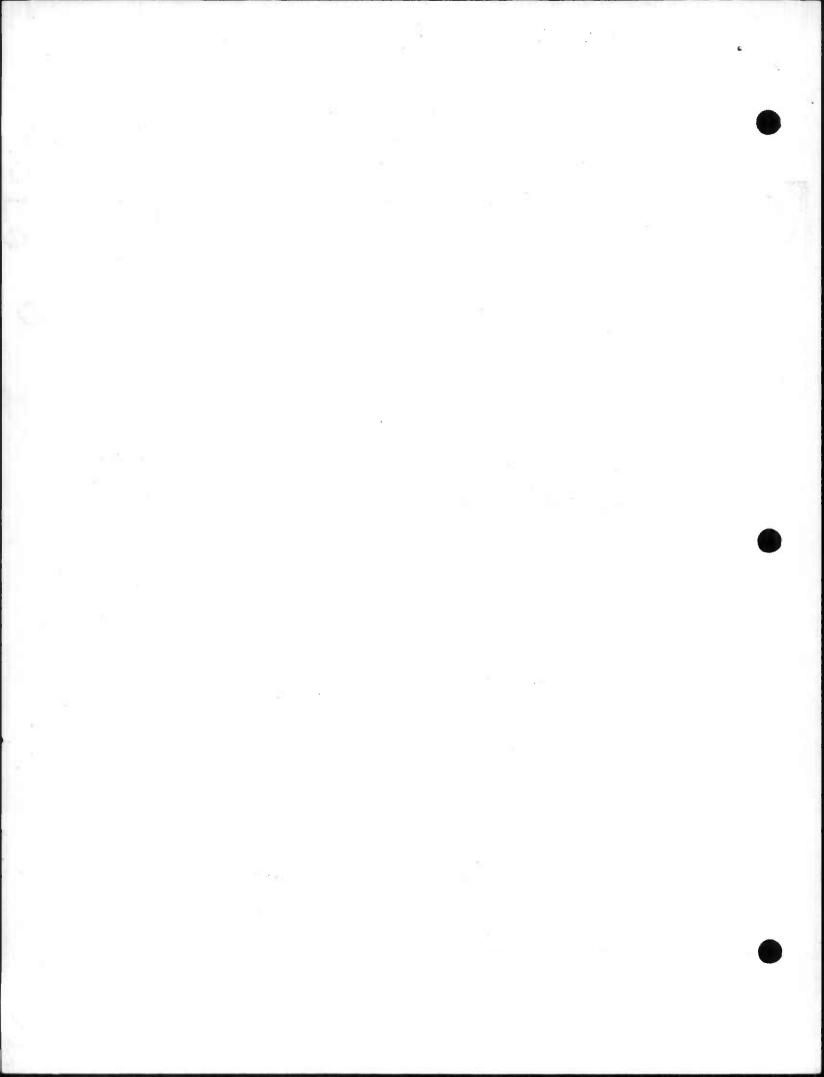
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the bospital or attending physician. TO THE FUNERAL DIRECTION After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit, be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR		CERTIF	CATE OF	DEATH	REG. NO.						
	t. DECEDENT'S NAME (First, Middle, Last) Anne	Louise	Ma	ck		2. DATE OF DEATH MONTH January 2	2 1995	3. TIME OF OEATH 3:30 P M				
	218-03-0926	□ M 2 💢 F	(In yrs. last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 6 / 22 / 19	8. BIRTI Count	HPLACE (State or Foreign my) MD				
TOR	98. FACILITY NAME (If not institution, give stree Berlin Nursing RESIDENCE OF DECEDENT			96. CITY, TOWN	or location of di		9c. COUNTY OF OEATH Worcester					
FUNERAL DIRECTOR	10e. STATE 10b. COUNTY	Worcester	10c. CIT	OCE	an City		100	10d. INSIDE CITY LIMITS? 1 YES 2 NO				
VERAL	100. STREET AND NUMBER 600 139th St.		10	1. ZIP CODE 21842		10g. CITIZEN OF WHAT COUNTRY?						
BY FUI	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER FORCES? 1X YE IF YES, GIVE WAR OR	S 2 NO	If yes, sp		NIC ORIGIN? (Specify Yea in, Puerto Rican, stc.)	Blac					
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)		171	rork done during mo e retired.)	on ost of working Secreta		SINESS/INDUSTRY	Laboratory				
MO	17. FATHER'S NAME (First, Middle, Last)	-				ME (First, Middle, Malden		Laboratory				
BEC	Nicholas Meek	ins			Lo	uise Elwood	d					
TO E	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow						
	George Mack 20a. METHOD OF DISPOSITION		Ob. PLACE AND DATE (F DISPOSITION (N	ame of	City, MD	CATION — City or To	own, Stata				
Í	1 Donation 5 Other (Specify)	of from State	ape Henle	open Cr	ematory	1/23/95 F	rankfor	d, DE				
į	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Burbage Funeral Home 108 Williams St. Berlin, MD 21811											
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, auch as cerdiac or reapiratory errest, ehock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Approximate interval Between Onset and Death 2.2 Lags CAUSE (Disease or injury Due TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.											
PHYSICIAN: MEDICAL C	ASHD with Brease Can	contributing to deeth	Diale Diale Hue & Ulerin	les M Ceart	cellite Tailui necr	PERFOR	RMED?	N. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
i i		IOSPITAL:		OTHER:	LACE OF DEATH (Ch							
	27. MANNER OF DEATH 1 A Netural 5 Pending	26a. DATE OF INJUR (Month, Day, Year	Y 26b. TIM	E OF 28c. IN.	JURY AT ORK?	6 Other (Specify) 26d. DESCRIBE HOW I	NJURY OCCURED					
TED BY	2 Accident Investigation 3 Suicide B Could not be detarmined	26a. PLACE OF INJU building, atc. (S)	RY At home, 1erm, a pecify)	YES 2 NO office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.											
TO BE C	29b. SIGNATURE AND VITLE OF CENTIFIER	29d. DATE SIGNED	3 — 95									
-	Gregorio Bellos	o, MD 442	DEATH (ITEM 27) (Type, 1 Beechwo	od P1. (Crisfield	, MD 21817	410-968	3-3149				
6	JAN 2.3 1995	32. REGISTRAN'S ON	SNATURE Roules	A.								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page be filed within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal. IMPORTANT: If Hem 28 is marked, or Hem 23 shows any Injury, or other traumatic event, the medical examiner must be in	y be	age		be
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral dire be filed within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner is	6 ma	ctor,		must
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. ITO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examin	Page	dire		-
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after of TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical expending the property of the control of the property of	leath.	funeral		xamin
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours a TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or rem IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medic	fter (the	oval.	9 6
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-7 not TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the m	JIS a	in by	rem	pa
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 23 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fibe filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the	P.	Pell	n, or	E
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crem IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event	7 U	ely fi	Dation	Ĕ.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and con be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic er	with	plet	сгел	rent
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exec TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and be filed within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to bu IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumati	uted	00	Tal.	9 3
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traus	exec	and	0 0	mat
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending phys be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene py IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other?	pe	ician	HOT 1	ē
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending be filed within 72 hours after death with the State Dept. of Health and Mental Hygies IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or oth	heate	phys	d au	10
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attent be filed within 72 hours after death with the State Dept. of Health and Mental HIMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or	certi	Sil B	ygie	to
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the TO THE FUNERAL DIRECTOR: After this certificate has been signed by 1 be filed within 72 hours after death with the State Dept. of Health and IMPORTANT: If Item 28 is marked, or Item 23 shows any In	e de	the a	Mer	Ē
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law re TO THE FUNERAL DIRECTOR: After this certificate has bee be filed within 72 hours after death with the State Dept. o IMPORTANT: If Item 28 is marked, or Item 23 sh	quire	n Sig	f He	M 0
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The la TO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dei IMPORTANT: If Item 28 is marked, or Item 2:	w re	Dee	0.0	3 sh
TO THE HOSPITAL OR ATTENDING PHYSICIAN: TY TO THE FUNERAL DIRECTOR: After this certificate be filed within 72 hours after death with the State IMPORTANT: If Item 28 is marked, or Iter	ne la	has	00	n 2
TO THE HOSPITAL OR ATTENDING PHYSICIAI TO THE FUNERAL DIRECTOR: After this certif be filed within 72 hours after death with the IMPORTANT: If Item 28 is marked, or	F	icate	State	Te
TO THE HOSPITAL OR ATTENDING PHYS TO THE FUNERAL DIRECTOR: After this obe filed within 72 hours after death with IMPORTANT: If Item 28 is marked.	ICIA	sertif	the	0
TO THE HOSPITAL OR ATTENDING F TO THE FUNERAL DIRECTOR: After 1 be filed within 72 hours after death IMPORTANT: If Item 28 is mar	HYS	this o	with	Ked
To the Hospital or Attendi To the Funeral Director: A be filed within 72 hours after of Important: If Item 28 Is	NG F	ther	ath	E L
TO THE HOSPITAL OR ATTI TO THE FUNERAL DIRECTO De filed within 72 hours aff IMPORTANT: If Item 28	ION	R. A	er de	60
TO THE HOSPITAL OR TO THE FUNERAL DIRING TO THE FUNERAL DIRING THE IMPORTANT: If Item	ATT	ECTO	s aft	1 28
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: II	OR	DIR	hour	ten
TO THE HOSF TO THE FUNE be filed within	TAL	RAL	172	=
TO THE F TO THE F De filed w	IOSP	UNE	rithin	ANT
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	10	10	be fil	E E

		•	•							9	5 1	04740		
		1 - FOR STATE REGISTRAR	STATE OF MARYL				IEALTH AI DEATH		AL HYGIENI REG. NO.	E				
		1. DECEDENT'S NAME (First, Middle, Last)			1/4	a11/5	// -	MON		γ .	YEAR 3	. TIME OF DEATH		
			H. SEX 6. AGE	(In yrs. last birthday	_		L, J					1800 "		
			7 M 2 F	78 YRS.	MONTHS	DAYS	HOURS N		25/1917	7 N	Country)	ACE (State or Foreign		
	OR	90. FACILITY NAME (If not institution, give stree PENINSULA REGIONA		CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY						TH CO		
L DIRECTOR	딥	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY	10c. CITY, TOWN OR LOCATION								10d. INSIDE CI			
		Maryland Worcester Pocomoke City									10d. INSIDE CITY LIMITS? 1 YES 25 NO			
	FUNERAL	100. STREET AND NUMBER 942 Ocean Highway					21851			10g. CITIZE	N OF WHA	AT COUNTRY?		
	ONE		2. WAS DECEDENT EVER	IN U.S.,ARMED	13			IISPANIC ORIG	IN? (Specify Yee	or No.— 1		- American Indien,		
	B	1 Never Merried 2 🔼 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 PNO		if yes, sp	ecify Cuben, N 2 ZNO	lexicen, Puerte	Pican, etc.)	01110-	Black, V Specify:	White, etc.		
	COMPLETED	15. DECEDENT'S EDUCA: (Specify only highest grade co Elementary/Secondary (0-12)			f work done use retired.	during mo	st of working	10	b. KIND OF BUS	INESS/INDUS	STRY			
eg	MP		2	Electr	ical	Eng:								
31 01	8	17. FATHER'S NAME (First, Middle, Last) Benjamin H. Mitche	11. Sr.				Clari		, Middle, Maiden S					
	TO BE	19e. INFORMANT'S NAME (Type/Print)		19b, MAILIN	IG ADDRES	SS (Street a			Han S	, State, Zip C	ode)	· · · · · · · · · · · · · · · · · · ·		
De 110	ř	Iku K. Mitchell 942 Ocean Hwy., Pocomoke, Md. 21851												
MUST		20s. METHOD OF DISPOSITION 1 Burlel 2 K Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory 2/1 Salisbury, Maryland												
examiner must	ļ	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Melson Funeral Home												
	-	23. PART I. Enter the disease or complications that caused the death Do not extra the made of this ways as a still a second to the second to t										.851		
medical		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiretory arrest, ahock, or heart fallure. List only one cause on each line.												
i, ille		MMEDIATE CAUSE (Final disease or condition resulting in death) a. ACUTE REVAC FAILURE										Onset and Death		
ever ever		DUE TO (OR AS A CONSEQUENCE OF):												
matile	S S	Sequentially list conditions, If any leading to immediate DUE TO (OR AS A CONSEQUENCE OF): UEE												
	CA	cause. Enter UNDERLYING CAUSE (Disease or injury C. DEMENTIA										YEARS		
or other	ERTIFICATION	that initiated events DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) LAST												
ا اغ	ᄗᆘ	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS												
amy in	MEDICAL	and the same of th	MONIA	out not resulting	in the u	inderlyin	g cauae give	n in Part i.	24a, WAS AN / PERFORI		A	ERE AUTOPSY FINDINGS ALLABLE PRIOR TO OMPLETION OF CASE		
D SWI			740,77						1 TYES 2	NO.	O	F DEATH?		
JUS C7	ž	DID TOBACCO USE CONTRIL	BUTE TO CAUSE C	OF DEATH Y	ES 🗆	NO [UNCER	TAIN			'	YES 2 NO		
E E	PHYSICIAN:		OSPITAL:	26. PLACE OF DE	ATH (Check									
	HYS	1 YES 2 NO	Inpatient 2 ER/Out	petient 3 DOA	4 🗆 Nu		5 Reside		er (Specify)	IIIBY OCCU	BED			
ps 1	BY P	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		IJURY M	WO	RK? 'ES 2 No		LOCKIDE HOW IN	JOH! OCCO!	HEU			
		3 Suicide 8 Could not be detarmined	28a. PLACE OF INJURY building, atc. (Spe	f — At home, term cify)	, street, tec	ctory, office		28t, LO	CATION (Street or y or Town, State)	nd Number or	Rural Rout	te Number,		
	COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA (Check only one) 2 MEDICAL EXAMINER:	N: To the best of my know											
- 1	_ 11	296. SIGNATURE AND TITLE OF CERTIFIES		/ Signor investigat	wii, iii miy	opinion, d	29c LICENSE		e end piace, and			grith, Day, Hear)		
		- fineled &	1. /					576		> 1/	31/	1		
- I '	≝ ∥	20 NAME AND ADDRESS OF DEDSON WHO	OUDI ETED PALISE OF DE		21.0					_	/			

DORESS OF PERSON WHO COMPLETED DAUSE OF DEATH (ITEM 27) (Type, Print)

RANGE P. TRALVITZ MD

TRAVITZ

32. REGISTRAR'S SIGNATURE

RONALD

1995

31. DATE FILED (Month, Day, Year)
FEB 0 3

MD

2180

	STATE REGISTRA
,	1. DECEDENT'S
ì	Keni

1, 2, 3 should

	1 - STATE STATE OF MARTEAND		ICATE	OF DEA	TH	AENIAL HYGIEN REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH MONTH DA	lv.	3. TIME OF OEATH					
	Kenneth CRISFIELD Mulliki	n				1 30		95 8:45 A M					
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs.		IF UNDER	T YEAR IF UNDE	R 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		6. BIRTHPLACE (State or Foreign Country)					
	213-01-8296 'X' M 2 🗆 F 81	YRS.				FEB. 21, 1	913	MARYLAND					
~	9e. FACILITY NAME (If not institution, give street end number)		9b. CITY,	Easto		ATH		TY OF DEATH					
2	Meridian - The Pines			albot									
DIRECTOR	10e. STATE 10b. COUNTY	10c. CIT	Y, TOWN O	R LOCATION				10d. INSIDE CITY					
5	MARYLAND TALBOT	EA	STON	I				1 WES 2 NO					
A	10e. STREET AND NUMBER			101. ZIP CO	DE		ZEN OF WHAT COUNTRY?						
FUNERAL	10149 THREE BRIDGE BRANCH	RD		21	601		τ	USA					
5	11. MARITAL STATUS 1 Never Merried 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2	ARMED NO	13, V	MAS DECENDENT	OF HISPAN	IC DRIGIN? (Specify Yee 1, Puerto Rican, etc.)	or No-	14. RACE — American Indian, Black, White, etc.					
BY	3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES	N.		TYES 2 XNO				Specify:					
E	15. DECEDENT'S EDUCATION 16s.	DECEDENT'S	USUAL OC	CUPATION		16b, KIND OF BUS	INESS/INDI	WHITE					
E	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of title. Do NOT ut	work done o se retired.)	luring most of work	ing		00.340						
Ā	5	PLUM	BER			PLUM	BING	3					
COMPLET	17. FATHER'S NAME (First, Middle, Lest)			18. MO	THER'S NAI	ME (First, Middle, Meiden	Surname)						
BE	EDWARD C. MULLIKIN			BEI	RTIE	V. HINTO	ON						
2	19e. INFORMANT'S NAME (Type/Print) KENNETH E. MULLIKIN					loute Number, City or Town							
·					KIDGI	1		, EASTON , MD					
ļ	20e. METHOD DF DISPOSITION 1 (A Burlel 2 Cremetion 3 Removal from State cappelor) 4 Donetton 5 Other (Specify)	ST.AWN	ther place!	Name of	PARI	Z 2-1 EAS	CATION — (MD					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22.1	NAME AND ADDR	ESS OF FAC	ILITY							
	NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD												
	23. PART I. Enter the diseases, or complications that caused the	death Do	not enter	the mode of d	HARI	RISON ST.	. , E/	ASTON, MD					
	shock, or heart failure. List only one cause on each i	ine.		0	mig, addi	r aa cordroc or roapi	ratory arti	Interval Between					
ı	immediate Cause (Final disease or condition and Death disease or condition resulting in death) - Concerting the first failure of the condition of the conditio												
	DUE TO (OR AS A CONSEDUENCE OF): A Walter Cardinase												
Z	Sequentially list conditions,												
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	SEDUENCE O	F):										
FIC	CAUSE (Disease Dr Injury C.	SEQUENCE O	FI:										
E	that initiated eventa resulting in deeth) LAST		. ,-										
	d												
MEDICAL	PART II. Other significant conditions contributing to deeth but no	ot reculting	In the un	derlying ceuee	given in	PERFOR	WED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO					
ă	Hypoteus ven					1 TYES 2	NO	OF DEATH?					
	Dialista mollitus		_			_		t 🗌 YES 2 🗎 NO					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			26. PLACE DF	DEATH (Chi	rck only one)							
SIC	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpetient	3 DOA	OTHER 4 X Nurs	:		6 Other (Specify)							
Ή	27. MANNER OF DEATH 28e. DATE OF INJURY	28b. TIM	E OF	28c. INJURY AT	- I	28d. DESCRIBE HOW II	NJURY OCC	CURED					
ВУ Р	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	in.	M	WORK?	□ NO								
	3 Suicide 6 Could not be 28e. PLACE OF INJURY — At building, etc. (Specify)	home, term,	street, facto	ory, office		281. LOCATION (Street e City or Town, Stete)	and Number	or Rural Route Number,					
COMPLETED	4 Homicide determined							<u> </u>					
IPLI	29e. CERTIFIER (Check-eat) 1 CERTIFYING PHYSICIAN: To the best of my knowledge,												
0	2 MEDICAL EXAMINER: Do the basic of examination end	or investigation	on, in my o	pinion, death occ	ared at the	time, date end place, en	d due to the	e cause(s) and menner as stated.					
BE	288. SIGNATURE AND TITLE OF CERTIFIER	1 .	11	29c. LH	ENSE NUM	BER	29d. DATE	SIGNED (Month, Day, Year)					
9	/ Junous D. STM		'V'	1 1	27	409	1.	20.45					
4	ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH I	TEM 27) YType	Print)	7011	1	10 211	(01						
ļ	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	F	4	7010		IV (X/C	100						
	and the state of t	_											

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trains be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

JAN 3 0 1995

Julia Diwelcon Rardall

DHMH-16 Rev 1/89

	1 - STATE REGISTRAR	SIATE OF I		RTIF	ICATE OF	DEALIN	TH	MENIAL HYGIEI REG. N					
1	1. DECEOENT'S NAME (First, Middle, L							2. DATE OF GEATH MONTH	DAY	YEAR	3. TIME OF OEATH		
1		. •	ller						27	95	10:35 am		
5	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. lest bi		IF UNDER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHI	PLACE (State or Foreign		
i i	062-14-0549	1 M 2 KF	89	YRS.				NOV.4,19	YORK				
œ	9a. FACILITY NAME (If not institution, g				9b. CITY, TOWN	OR LOCATIO	ON OF DE	ATH	9c. CO	UNTY OF DE	EATH		
<u>ē</u>	WILLIAM HILI	MANOR			EA	STON				TALE	ВОТ		
DIRECTOR	10a. STATE 10b. CO		1	loc. CITY	Y, TOWN OR LOCA	TION			10d. INSIDE CITY				
5	MARYLAND	TALBOT			EAST	ON			LIMITS?				
AL	10e. STREET AND NUMBER					H. ZIP CODE	E		HAT COUNTRY?				
FUNERAL	501 DUTCHMAN					2	160	1		USA			
5	11. MARITAL STATUS 1 Never Merried 2 Married	FORCES? 1	T EVER IN U.S. ARME	D	13. WAS DE	CENDENT O	F HISPAN	IIC ORIGIN? (Specify Yon, Puerto Rican, atc.)	s or No-	14. RACE Black	- American Indian, White, etc.		
B	3 XWidowed 4 Divorced	MAR OR DATES			S 2X NO				Specif				
	15. DECEDENT'S		16a. DECEI	DENT'S	USUAL OCCUPAT	ION		16b. KIND OF B	JSINESS/IN	NDUSTRY	MILLE		
	(Specify only highest (Elementary/Secondary (0-12)	(rade completed) College (1-4 or 5 -	(Give i	kind of v	vork done during n e retired.)	ost of workin	g						
린	12	4		НО	MEMAKE	R		OWN	HON	ME			
COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTH	IER'S NA	ME (First, Middle, Maide					
BE (EDWARD HISNA	Y				AR	ANK	A MESARA	S				
2	19a. INFORMANT'S NAME (Type/Print)	LYN						Route Number, City or To					
	EDWARD M.	PHILLIP					R.,	RIDGEFI					
	1 Buriel 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from State	cametery cremat	tory or of	OF DISPOSITION (A ther place)					- City or Tov			
	21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE	SALISE	JUK	Y CREM	ATOR			TrISI	BURY,	MD		
	+ B. Kert	I Phys	in, CF	5 F	NEWN			RAL HOME					
	23. PART I. Enter the diseases,	//			200	S. H.	ARR.	ISON ST.	, EA	ASTON	Approximate		
	ahock, or heert falls IMMEDIATE CAUSE (Final disease or condition resulting in death)	a.	Meran	in	i Pr	reur	un	un			Interval Between Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in deeth) LAST												
PHYSICIAN: MEDICAL	PART II. Other algnificant cond	ulting i	n the underlyi	ng ceuse ç	given in		RMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
CIA	25. WAS CASE REFERRED TO MEDICA EXAMINER?	HOSPITAL:				LACE OF D	EATH (Ch	ack only one)					
YSI	1 TES 2 A		ER/Outpatient 3	DOA	OTHER: Nursing Ho	me 5 🗆 Re	sidence	6 Other (Specify)					
F	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF (Month, D	INJURY 2 lay, Year)	8b. TIMI INJ	URY W	JURY AT ORK?		28d. DESCRIBE HOW	INJURY O	CCURED			
B	2 Accident Investigat		F INJURY — At home,	4		YES 2	NO						
딢	3 Suicide 6 Could not 4 Homicide determine	building,	etc. (Specify)	, 1017111, 1	ereet, factory, om	ce	- 1	281. LOCATION (Street City or Town, State		er of Hural H	oute Number,		
COMPLET	29a. CERTIFIER 1 CERTIFYING P	HYSICIAN: To the beat of	my knowledge death	00000	of at the time day	a and place	and due	In the country and m		241			
M		MINER: On the basis of a									and menner as stated.		
	29b. SIGNATURE AND TITLE OF CERT		7/1			_	NSE NUM				(Month, Day, Year)		
TO BE	William	HOWO	00(1)	/	MI)	10	08	715	290, 04	1/2	7/95		
	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUS	SE OF DEATH SIEM 2	7) (Type,	Print) (M1)	/-	ZA	STON	MI	1 >	1601		
	31. DATE FILED (Month, Day, Year)	32. REGISTRA	R'S SIGNATURE				8	(/ 80/		

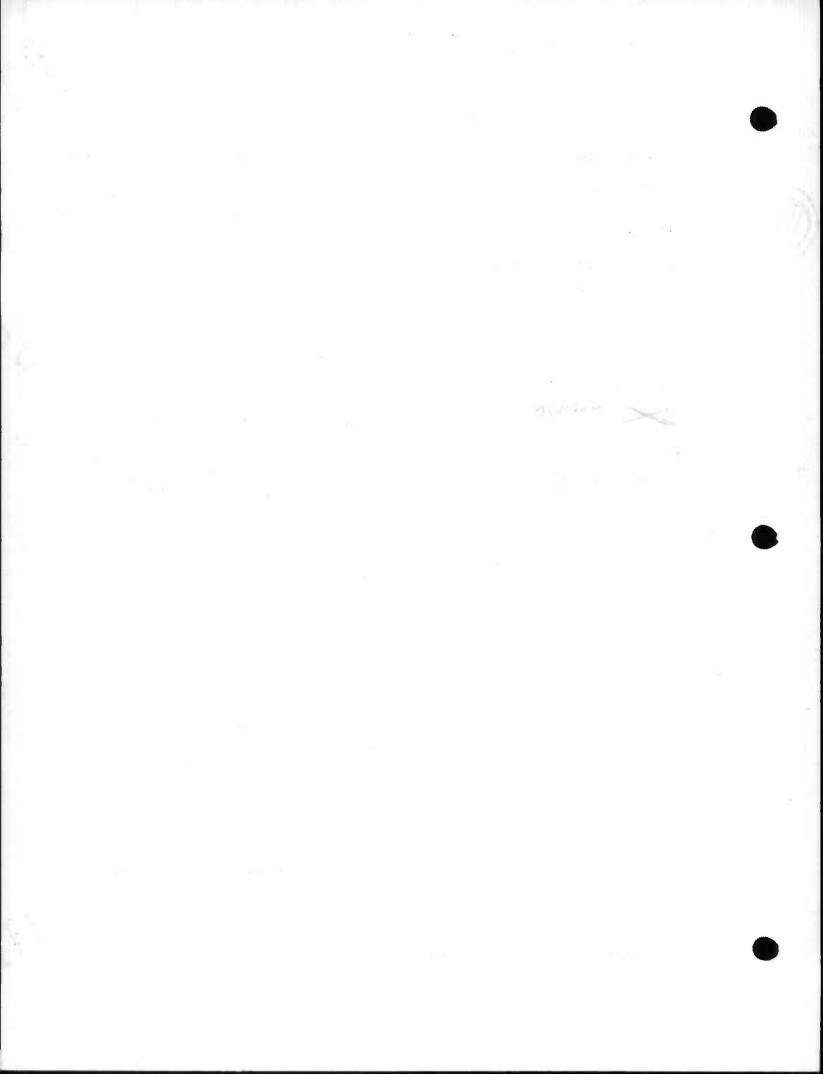
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within yours after death. Page 6 may be retained by the law requires that the attending physician and completely filled in by the funeral director, page 5 should be definited by the burish transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notitied at once.

JAN 3 0 1995

June Barren Kardell

DHMH-16 Rev 1/89



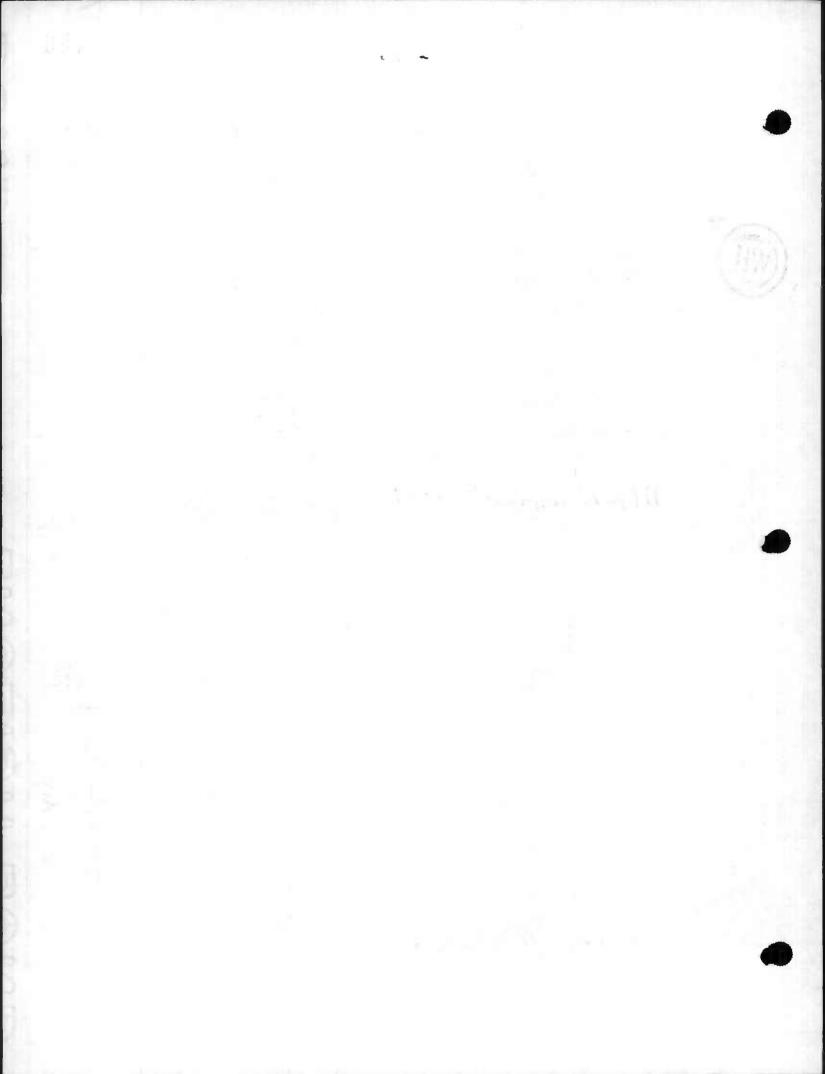
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

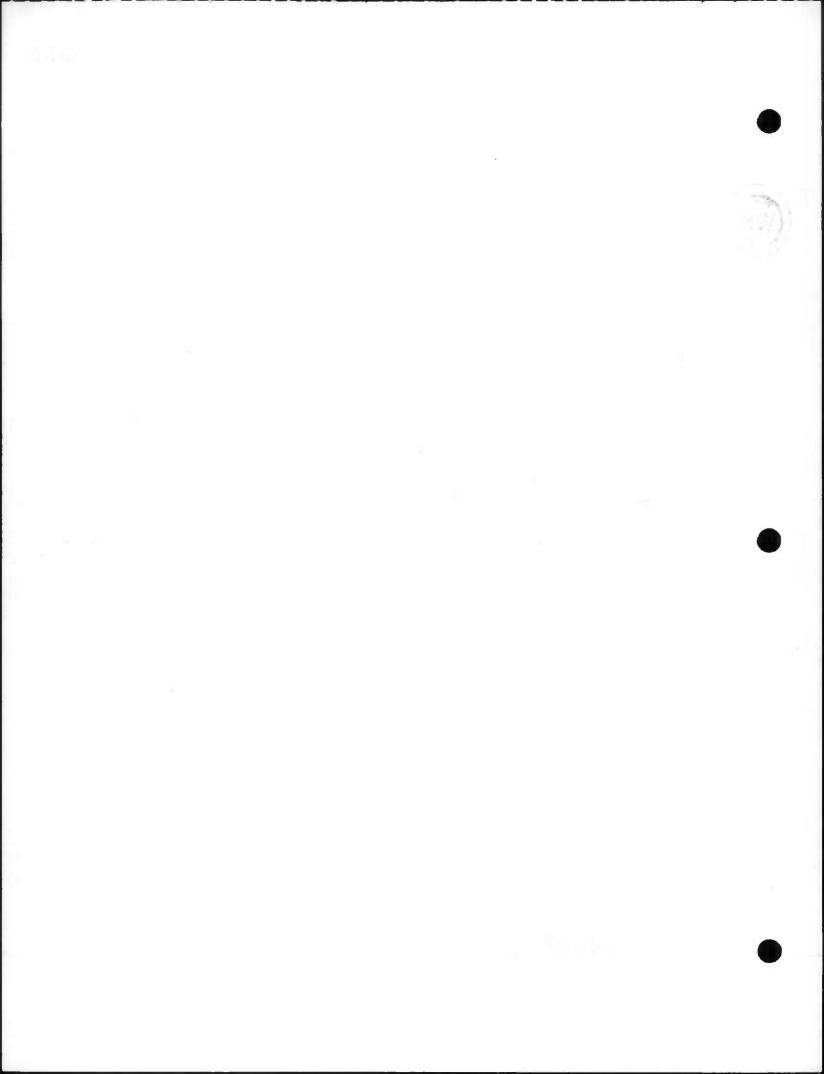
1 -	FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR	CERTIF	ICATE OF	DEATH	REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH				
	DANIEL RICHARD	Meeha	an		MONTH 63	1 95"	8:54 A M				
9	4. SOCIAL SECURITY NUMBER 6. SEX	3. AGE (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	HPLACE (State or Foreign				
	216-16-1927 XX 2 🗆 F	72 YRS.	MONTHS DAYS	HOURS MIN.	JUNE 2,1	922 MAI	RYLAND				
	9a. FACILITY NAME (If not institution, give street and number)	-	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH								
TOR	WILLIAM HILL MANOR		E	ASTON		TALE	BOT				
量	10a. STATE 10b. COUNTY	10c. CIT	Y, TOWN OR LOCAT	TION			10d. INSIDE CITY LIMITS?				
DIRE	MARYLAND TALBOT		EAS	TON			1 X YES 2 NO				
	10e. STREET AND NUMBER		101	. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?				
FUNERAL	501 DUTCHMAN'S LANE			21601		1					
5	FOROTER 4 N	EVER IN U.S. ARMED			NIC ORIGIN? (Specify Yea	or No- 14, RAC	CE — American Indian, ck, White, stc.				
BY F	1 Never Married 2 Married XXWIdowed 4 Divorced F YES, GIVE WW TT			2 NO Specif	n, Puerto Rican, etc.) y:		city: WHITE				
Q	15. DECEDENT'S EDUCATION	16a. DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND OF BUS	INESS/INDUSTRY					
	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of life. Do NOT u	work done during mo se retired.)	ast of working	11-2-2-1						
립	12	REVIS	ER		PRINT	ING CO	MPANY				
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)			16. MOTHER'S NA	ME (First, Middle, Maiden	Surname)					
BE (DANIEL A. MEEHAN			MAR	Y I. HAN	NAN					
2	19a. INFORMANT'S NAME (Type/Print)		The state of the s		Route Number, City or Town						
-	JEAN P. WILSON			-	MICHAELS						
	20a. METHOD OF DISPOSITION 1	20b. PLACE AND OAT OF COMPETER				ISBURY					
117	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		O	NO ADDRESS OF FA	CILITY						
	M. F. Newyane	U CFS			ERAL HOMERISON ST						
	23. PART I. Enter the diseases, or complications that						Approximata				
	shock, or heart failure. List only one caus IMMEDIATE CAUSE (Final	e on each line.					interval Between Onset and Death				
- 17	disease or condition resulting in death) a. Vessing tous tail use.										
	DUE TO (OR AS A CONSEQUENCE OF):										
Z	Sequentially list conditions, 6.		nenju	ma							
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	OR AS A CONSEQUENCE		also a	11	4	78.				
고 고	CAUSE (Disease or injury	OR AS A CONSEQUENCE O		wee n	ecen -		l l				
H	reaulting in death) LAST		,		meumon	ia)					
CE											
	PART II. Other algorificant conditions contributing to c		1 0		PERFOR	IMED?	No. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO				
DICAL	How to chini	c pen	al 1	publi	COU 1 VES 2	NO	COMPLETION OF CAUSE OF DEATH?				
2		<u> </u>		110	_ \	,	1 YES 2 NO				
ż											
PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:		26. P	LACE OF DEATH (C)	heck only one)						
YSI	1 YES 2 NO 1 Inpetient 2	ER/Outpatient 3 DOA		ne 5 🗆 Rasidenca	6 Other (Specify)						
F	27. MANNER OF DÉATH 1 Netural 5 Pending		JURY W	JURY AT ORK?	28d. DESCRIBE HOW I	NJURY OCCURED					
BY	2 Accident Investigation			YES 2 NO							
	3 Suicide 6 Could not be 4 Homicide detarmined	INJURY — At home, ferm. rtc. (Specify)	street, factory, offic	on .	28f. LOCATION (Street a City or Town, State)		I Route Number,				
H	29a, CERTIFIER	7	_								
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the basis of any	/					e(a) and manner as stated.				
	PHE SIGNATURE AND TITLE OF CENTIFIER		1	29c. LICENSE NU	IMBER CO 1	29d. DATE SIGNI	ED (Month, Day, Year)				
3 BE	When I toler)	20	2824	· 2	1195				
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUS	E OF QUATH STEM 27) (Typ	Pring	508	3 DUEW	ILD	AVENUE-				
r	MYSTAT 1. SHOWKIN	RN 211	YVVY.	日	FSDNI m	A Ru Con	2 2160)				
	31. DATE FILED (Manth, Day Your) 1995 July William William	SIGNATURE CLICAL PARTIES									



	1. DECEDENT'S NAME (First, Middle, Last) Anna Alice Ellen MELVIN 2. DATE OF DEATH DAY FEBRUARY 6, 1995											3. TIME OF DEATH 6:00 pm m		
	4. SOCIAL SECURITY NUMI 213-40-338	1	5. SEX 1 ☐ M 2 🏹 F	6. AGE (In yrs. les 84	t birthday) YRS.	# UNDER	1 YEAR DAYS	IF UNDER	24 HRS. WIN.	7. DATE Dec	OF BIRTH	LO	8. BIRTH	PLACE (State or Foreign
TOR	90. FACILITY NAME (# not h 1904 Park	Mills	,			l .		S LOCATION		ATH			ederi	
FUNERAL DIRECTOR	100. STATE Maryland	10b. COUNTY	derick				N OR LOCATION							10d. INSIDE CITY LIMITS? 1 YES 2 X NO
ERAL	100. STREET AND NUMBER 1904 Park		Road				10	1. ZIP CODI	710			10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
B⊀	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2 X	MED IO		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yee, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ YES 2 ▼ NO Specify: 1. ARACE — Bleck, WP Specify:					E — American Indian, k, White, etc. White		
COMPLETED	15. DEC (Specify onl Elementery/Secondery (I	ve kind of to Do NOT us	ENT'S USUAL OCCUPATION Ind of work done during most of working NOT use retired.) Emaker					KIND OF BUS	Home					
BE CO	17. FATHER'S NAME (First, Middle, Last) Harry Woodrow COSGRAVE 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Ollie DIXON													
2	190. INFORMANT'S NAME (Type/Print) Mr. H. Richard Melvin 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6906 Colonial Avenue, Thurmont, Maryland 21788													
	20e. METHOD OF DISPOSIT LX Burlel 2 Cremetic 4 Donation S Other 21. SIGNATURE OF FUNETIA	(Specify)		cemetery, cre Mount	MATE OLI	ther plece)	Ceme	etery		9,1	995 F	reder	cick,	Maryland
	Aklu	ren ko	Beisi	w MOC	706	Ke	ene	,	Basfo	ord I	A. Fre			ome 4D 21701
	23. PART I. Enter the d shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eart fellure.	List only one cau	t coused the de ise on each line LUL (OR AS A CONSECUTION		Hee		de of dyl		,		ratory en	rest,	Approximate interval Between Onset and Deeth
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
AL CE											WAS AN AUTOPSY 24b. PERFORMED?		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO	
: MEDICAL	DID TOBACCO U	ISE CONTI	DIDLITE TO CA	LISE OF DEA	TU VI		10 13	5 11010	FDTAIA		1 TYES 2	No No		COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED T EXAMINER?	7	HOSPITAL:			TH (Check	only one)	Z UNC	EKIAIP					
HYS	1 YES 2 NO 27. MANNER OF DEATH		1 Inpatient 2 I	INJURY	28b. TIM	4 Nun		URY AT	sidence		(Specify)	JURY OC	CURED	
B	2 Accident	Pending Investigation	(Month, D	ay, Year) FINJURY — At hor		M M	1 🗆	YES 2] NO		ATION (Street o			Doube Atombas
ETED	4 Homicide	Could not be determined	building,	etc. (Specify)						City	or Town, Stete)			note Humber,
COMPLETED	(Check only		CIAN: To the best of R: On the bests of ea											e) end mattner ee stated.
B	296, SIGNATURE AND TITLE	OF CERTIFIEF							3555					(Month, Day, Year)
٩	30. NAME AND ADDRESS OF Dr. Judith		erb Henry	, M.D.,	610	Nint	h A				vick,			
	31. DATE FILED (Month, Day, FEB 0		32. REDISTRA	R'S SIGNATURE	ardall	ì			-					



3. TIME OF DEATH

9:30

8. BIRTHPLACE (State or Foreign

Virginia

10d. INSIDE CITY

14. RACE — American Indian, Black, While, etc.

1 YES 2 NO

1 TES 2 NO

White

Frederick

10g. CITIZEN OF WHAT COUNTRY?

United States

Specify:

DIRECTOR

FUNERAL

ΒY

ETED

COMPL Once.

BE

0

25. WAS CASE REFERRED TO MEDICAL

290. BIGNATURE AND YIPCE OF CERTIFIED

ERRY

Investigation

1 TYES 2 NO

27. MANNER OF DEATH

1 Natural

2 Accident Sulcide

4 Homicide

29e. CERTIFIER

use as the burial-transit

BALTIMORE, MARYLAND 21215-0020

HELEN

RESIDENCE OF DECEDENT

1 Never Merried 2 Merried

Elementary/Secondary (0-12)

(Specify or

3 Widowed 4 Divorced

9e. FACILITY NAME (If not institution, give street and number

Doubs

4. SOCIAL SECURITY NUMBER

226-14-1767

Maryland

5616

11. MARITAL STATUS

10e. STREET AND NUMBER

CLARK

Frederick Memorial Hospital

Road

10b. COUNTY

15. DECEDENT'S EDUCATION

5. SEX

Frederick

1 🗌 M 2 😿

MYERS

IF UNDER 1 YEAR

10c. CITY, TOWN OR LOCATION

Adamstown

18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working

(Give kind of work done life. Do NOT use retired.)

IF UNDER 24 HRS.

9b. CITY, TOWN OR LOCATION OF DEATH

10f. ZIP CODE

1 TES 2 NO

21710

If yee, specify Cuben, Mexicen, Puerto Rican, atc.)

Specify:

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-

Frederick

8. AGE (In yrs. last birthday)

89

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES

College (1-4 or 5+)

9c. COUNTY OF DEATH

REG. NO

1995

190

18b. KIND OF BUSINESS/INDUSTRY

28d. DESCRIBE HOW INJURY OCCURED

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29d. DATE SIGNED (Month, Day, Year)

#307

55

2. DATE OF DEATH

Jan. 30,

7. DATE OF BIRTH
(Month, Day, Year)
July 11,

PHYSICIAN: MEDICAL CERTIFICATION

BY

ETED.

COMPL

BE

2

item ;

TO THE FUNERAL D
be filed within 72 h
IMPORTANT: If IN HOSPITAL

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

10	HO MEMAKER	Own						
17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME	(First, Middle, Maiden Surname)						
A.B. Clark		Anderson						
19e. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Ro	ute Number, City or Town, State, Zip C	Code)					
John S. Barret, Jr.	5616 Doubs Road Adam	stown, Marylan	d 21710					
20e. METHOD OF DISPOSITION 1 Meurial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) Resthaven Memorial Gardens	DATE 20c. LOCATION — CH						
21. SIGNATURE OF FUNERAL SERVICE LIGHTSEE	22. NAME AND ADDRESS OF FACIL	^m Stauffer Fune	ral Homes, P.A					
23. PART L Enter the diseases, or complications that of shock, or heart failure. List only one cause	aused tha death. Do not enter the mode of dying, such on each line.	ns cardiac or respiratory arres	it, Approximate					
	ER KALEMIA R AS A CONSEQUENCE OF):		Onset and Daath					
if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	FAILURE R AS A CONSEQUENCE OF): FAILURE R AS A CONSEQUENCE OF): FCASCON		2 days 5 days years					
PART II. Other significant conditions contributing to de	ath but not resulting in the underlying causa given in Pa	ert I. 24s. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 P≦NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN

ETED CAUSE OF DEATH (ITEM 27) (Type, Print)

☑Inpatient 2 ☐ ER/Outpatient

28e. PLACE OF INJURY — At he building, etc. (Specify)

28e. DATE OF INJURY (Month, Day, Year)

164

32. REDISTRAT'S SIGNATURE

HOSPITAL:

28. PLACE OF DEATH (Check only one)

28b. TIME OF

1 🖾 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated.

4 Nursing Home 5 Residence 8 Other (Specify)

29c. LICENSE NUMBER

28c. INJURY AT WORK?

2 MEDICAL EXAMINER: On the besie of exemination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end menner ee stated.

1 YES 2 NO

WH	permitted 2, 3 should
BALTIMORE, MARYLAND 21215-0020	er death. Page 6 may be retained by the hospital or attending physiciem, the funeral director, page 5 should be detached for use as the burial-transit ret.

signed by the attending physician and completely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal.

has been a

this certificate has with the State C

After

DIRECTOR: A

FUNERAL I within 72 h

TO THE HOSPITA
TO THE FUNERA
Be filed within 7.

23

10

marked.

28 is

OR ATTENDING PHYSICIAN: The law

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notified

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must

examiner

medical

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traumatic

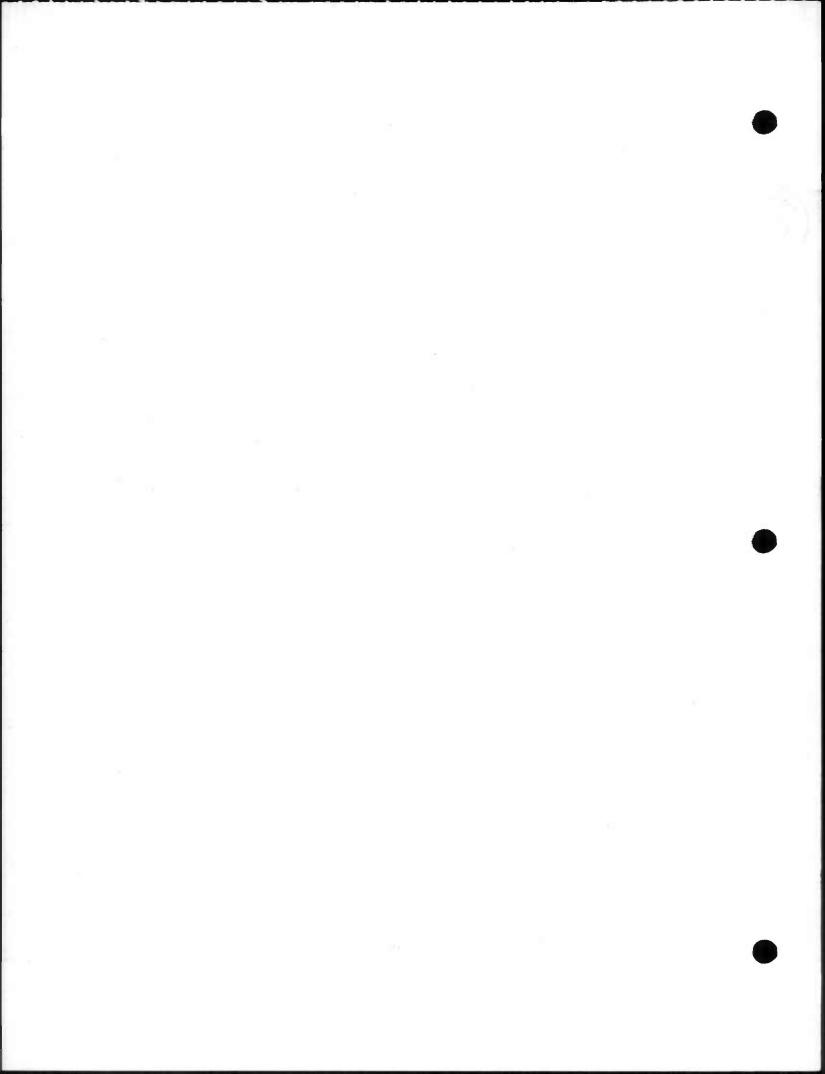
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1 -1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Robert Louis Main February 3. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 5. SEX 7. DATE OF BIRTH May 8 1920 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 578 03 7822 74 Maryland 1 🔯 M 2 🗌 I 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN P.O. Box 3071 1219 Defense Highway DIRECTOR Crofton Anne Arundel RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Calvert Broomes Island 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4140 Penkert Lane 20615 United States 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-II yes, specify Cuben, Mexicen, Puerlo Ricen, atc.)

1 YES NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1X YES 2 IF YES, GIVE WAR OR DATES 1 Never Merried 2 Merried Specify: white BY 3 Widowed 4 Divorced WWII COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) Public Works/Adim. Asst P.G. County Gev. 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Irwin Ingram Main Sr. Elizabeth Jane Dunnington 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 3071 Crofton Maryland 20114 21/1/4 Patrick I. Main DAGS 20c. LOCATION — City or Town, State 20e. METNOD OF DISPOSITION
1 □ Burlel 2 X Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of February 7 of Alexandria Virginia 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic Maryland 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart fellure. List pnly one ceuse on each line interval Between **IMMEDIATE CAUSE (Finel** Onset and Death disease or condition resulting in death) touts. verit. DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate Car dumno faith cause. Enter UNDERLYING CAUSE (Diseese or Injury that initieted evente resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. 24e. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 1 TES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES, NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL OTHER: 1 YES 2 NO ☐ Inpatient 2 M ER/Outpatient 3 M DOA 4 Nursing Home 5 - Relidence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 26b. TIME OF 28c. INJURY AT WORK? 1 Natural 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(s) end menner ee stated. 2 MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end menner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE azdam DI. womana 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) Kioumarce Yazdani, M.D. 2555 Solomons Is. Rd. N. HuntingtownMD 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Davilson Rardall 06

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DHMH-16 Rev 1/89

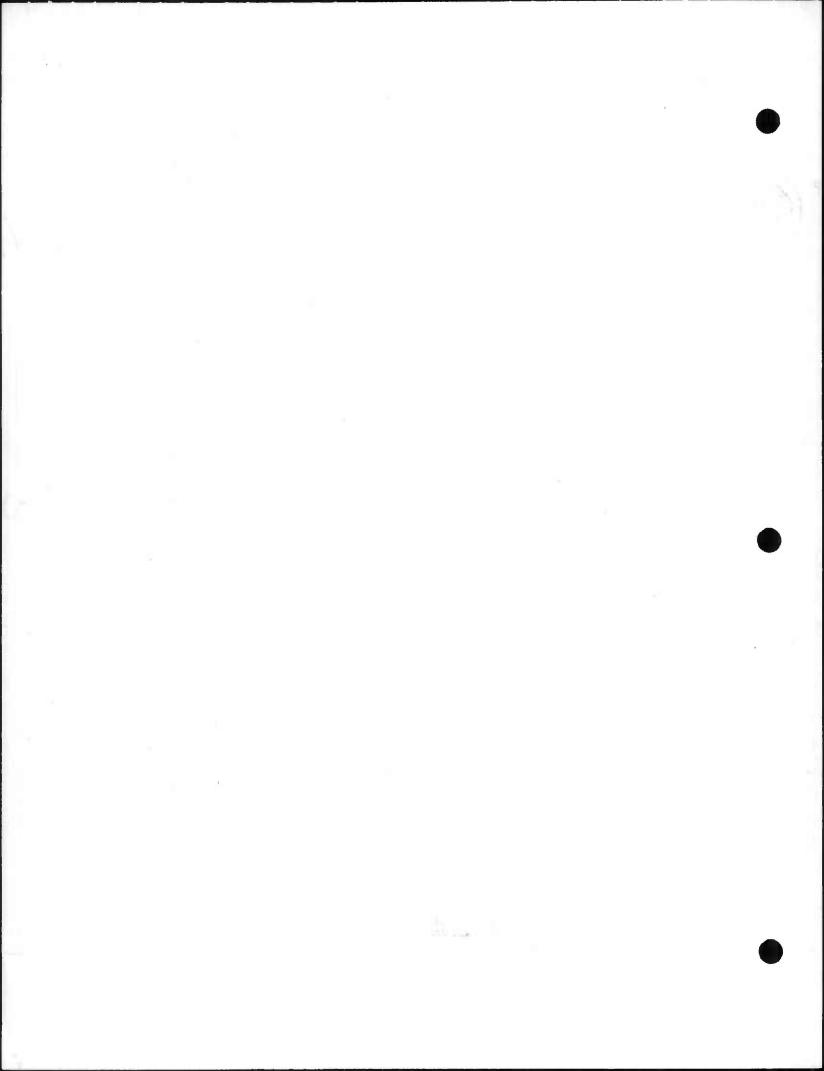


DIVISION OF VITAL RECORDS, P.O. BOX 68760

and the state of t	cuted within 24 hours after death. Page o may be retained by the hospit	d completely filled in by the funeral director, page 5 should be detached	urial, cremation, or removal.	ic event, the medical examiner must be notified at once.
THE MOCEITAL OB ATTENDIAG BUYCKTANI. The lass sequines that the dear	TO THE MOST INC. OF ALTERNATIVE PROSPRING THE INVESTIGATION OF THE PROSPRING OF EXPOSED WITHIN 24 HOURS STIRL DEATH. PAGE 6 MAY BE FRIANCED BY THE HOSPIT	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR			CERTIF	CATE OF	DEATH		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DEATH			3. TIME OF DEATH
	Eleanor	D.		Milw	1217		Janua	DAY 2.0	v), 19	YEAR	1:00 P
	4. SOCIAL SECURITY NUMBER		8. AGE (In yrs	last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF), I		IPLACE (State or Foreign
1	277-24-3071	1 🗆 M 2 🔯 F		YRS.	MONTHS DAYS	HOURS MIN.	(Month, D	ley, Year)		Count	(Y)
	9a. FACILITY NAME (If not institution, give a		88	April 13, 19							Dhio
or I				9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE							
ō	Rockville Nursin	ng Home			Rock	ville			Mo	ntgo	mery
្ត	IA. STATE										
E				10c. C11	, TOWN OR LOCA	TION					10d. INSIDE CITY LIMITS?
0		ntgomery		P	otomac						1 TES 2 NO
BY FUNERAL DIRECTOR	10e. STREET AND NUMBER				to	f. ZIP CODE			tog. CIT	ZEN OF	WHAT COUNTRY?
EF	1316 Fallsmead W	lay				20854			Uni	ted	States
5	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S.	ARMED	ts. WAS DE	CENDENT OF HISPA	NIC ORIGIN? (S	Specify Yes			E — American Indian, k, White, alc.
7	1 Never Married 2 Married	FORCES? 1 [IF YES, GIVE WA		[X] NO		Decify Cuban, Maxic		en, atc.)	i	Speci	
	3 🔀 Widowed 4 🗌 Divorced					y z Kij (10 opoci	·y·			Spec	White
COMPLETED	15. DECEDENT'S EDU	CATION	16a.	DECEDENT'S	USUAL OCCUPAT	ON	16b. KI	ND OF BUS	INESS/IND	DUSTRY	
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	_	(Give kind of w life, Do NOT us	ork done during m retired.)	ost of working					
7	12	College (1-4 of 5 +)	η.	alanha	ne Oper	ator		hio B	2011	mala	mh an a
S	17. FATHER'S NAME (First, Middle, Last)		1 7	erepno	ne oper	18. MOTHER'S N				rere	phone
	Daniel O'Grady	,							Sumame)		
BE			_			Mary					
2	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS (Street	and Number or Rural	Route Number,	City or Town	, State, Zip	Code)	
- 1	Daniel A. Milway			1316	Fallsme	ad Way,	Potoma	c, Ma	ryla	ind	20854
	20a. METHOD OF DISPOSITION 1) Burial 2 □ Cremation 3 □ Rame	med trom State	20b. PLA	CEANDDATEC	F DISPOSITION (N	. 4, 199	DATE	20c. LOC	ATION —	City or To	wn, Stata
	4 Donation 5 Other (Specify)	Over from State	Holv	Cross	Cemete	rv	1	Clev	elan	d. C	hio
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	₩00		_22. NAME A	ADDRESS OF F. A. Pumj ille, Ind	KÇILITY	1020.	-	, .	
	K. b. am	m. la	1.7	hence	Rocky	A. Pum	ohrey l	Funer	al H	ome/	m 0 1011
	Darboro you	in juccian	U		Avenue	Rocky:	ille,	Maryl	and	2085	0-2805
	23. PART I. Enter the discusses, or canonical shock, or heart failure.	complications that	caused the	death. Do n	ot enter the me	ode of dying, suc	ch as cardiac	or respin	atory an	rest,	Approximata
	IMMEDIATE CAUSE (Finsi										Onset and Deat
	disease or condition	DUE TO (C	0 32/	212							24 hour
ŀ	resulting in death)	DUE TO (C	H AS A CON	SEQUENCE OF):						-/ nogr
-	_				,·.						j
CERTIFICATION	Sequentially list conditions,	bDUE TO (C	R AS A CON	SEOUENCE OF	١٠						
A	if any, leading to immediate cause. Enter UNDERLYING				,•						
윤	CAUSE (Disesse or Injury	DUE TO (C	R AS A CON	SEQUENCE OF							
Ē	thet initieted events resulting in death) LAST	, , , , , , , , , , , , , , , , , , , ,		OCCOUNTING OF	,.						i
英		4									
	PART II. Other significent condition	a contributing to d	eeth but no	ot resulting in	the underivin	g ceuse given in	Part I. 24	a. WAS AN A	UTOPSY	24h	WERE AUTOPSY FINDINGS
EDICAL	Coronary ARter			•				PERFORM		1	AVAILABLE PRIOR TO COMPLETION OF CAUSE
	Hyper KASION						1	YES 2	NO NO		OF DEATH?
Σ	_//										1 TYES 2 NO
ż	DID TOBACCO USE CONTR	RIBUTE TO CAU	SE OF D	EATH YE	S I NO I	UNCERTAI	N 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. Pi	LACE OF DEAT	H (Check only one)						
Š	1 TES 2 X NO	1 Inpatient 2 8	R/Oulpatient	3 🗆 DOA	OTHER: 4 X Nursing Hor	e 5 🗆 Rasidence	8 Other (S)	pecify)			
ξI	27. MANNER OF DEATH	26s. DATE OF IN		28b. TIME		URY AT	28d. DEŞCRI	BE HOW IN	JURY OCC	CURED	
	1 Netural 5 Pending 2 Accident Investigation	(Month, Day,	rear)	INJU		YES 2 NO					
B	• 🗆 • • • • • • • • • • • • • • • • • •	28s. PLACE OF	INJURY At	home, farm, st	reet, factory, offic		28f. LOCATIO	ON (Street or	rd Number	or Rural F	loute Number
	4 Homicide 8 Could not be detarmined	building, et	c. (Specify)			-		own, State)	I HUMBU	Or Huran r	oute reamber,
	An CERTIFIER										
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSIC										
8	one) 2 MEDICAL EXAMINE	R: On the basis of axa	mination and/	for investigation	, in my opinion,	leath occured at the	time, data and	f place, and	dua to th	a cause(a) and manner as stated.
E C	296. SIGNATURE AND TITLE OF CONTY IEF	1				29c. LICENSE NU	MBER		29d DATE	FSIGNED	(Month, Day, Year)
	arthur Schoe					30 30 -11	_		.		
2	30. NAME AND ADDRESS OF PERSON WHO	- 4	OF DEATH #	TEM 27 /5	Defeat	D1872	ь		' Ja	anua	ry 31, 1995
										_	
					('on+ou	17	12 1	77 -	B/	-7	
ļ	Arthur. Schoengold	1, M.D.	7/15 M	euicai	Center	Drive,	ROCKVI	.ire,	Mary	Zano	20850
	31. DATE ELLED (Month, Den Year) 95	ST REGISTRAR	SIGN OF	dell .	center	Drive,	ROCKVI	ile,	Mary	Ziano	20850



TO BE COMPLETED BY FUNERAL DIRECTOR

			CE	:KI IFI	CATE OF	DEAL	THI I		REG. NO.				
1. DECEDENT'S NAME (First, MI	ddle, Last)	11		4 -				MONTE	OF DEATH	NY .	YEAR	3. TIME OF DEATH	
4. SOCIAL SECURITY NUMBER	/	<u> </u>			91/11	7			vary 2	9,19	95	120P "	
183-03-1810		S. SEX	B. AGE (In yrs. les	4	WONTHS DAYS	HOURS	24 HRS.	7. DATE (Month	OF BUITH	"]	B. BIRTHP	LACE (State or Foreign	
9a. FACILITY NAME (If not institu			79	YRS.					4, 1			Jersey	
					96. CITY, TOWN			EATH		9c. COUNTY OF OEATH			
4115 51st.		F 304			Blade	ensbur	rg			P	·G.		
	b. COUNTY			10c. CITY	, TOWN OR LOCA	TION					Т	10d. INSIDE CITY	
MD.	P.	G.			Blader	sburg	y*					LIMITS?	
10e. STREET AND NUMBER						r. ZIP CODE				10a, CITIZ		IAT COUNTRY?	
4115 51st.	St. #	4 304				2071	0				S.A		
11. MARITAL STATUS		2. WAS DECEOENT			13. WAS OF			IIC ORIGIN	? (Specify Yee				
	1 Never Merried 2 Merried FORCES? 1 YES 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DA					pecify Cuber S 2 NO	n, Mexice	n, Puerlo F	lican, etc.)		Black, Specify	- American Indien, White, etc. White	
15. DECEDI (Specify only his	NT'S EOUCAT	TION	16a. OE	EDENT'S	USUAL OCCUPAT	ON		18b.	KIND OF BUS	INESS/INDU	STRY		
Elementary/Secondary (0-12)		mpleted) College (1-4 or 5+)	(Gh	ne kind of w Do NOT use	ork done during m e retired.)	ost of working	g						
12			Se	ectio	n Super	visor	71		H.	U.D.			
17. FATHER'S NAME (First, Middle	e, Last)					_		ME (First, A	fiddle, Meiden				
James L.		hinson				N	lary	Ca	vanau	zh			
19a. INFORMANT'S NAME (Type					ADDRESS (Street	end Number	or Rural F	Route Numb	er, City or Town	, State, Zip (
Joseph A.	MCGILL	IN 111		402	- 98th.	Ave.	Sea	abroc	k, MD.	2070	06		
20a. METHOD OF DISPOSITION 1 ■ Burial 2 □ Cremation	2 Romove	of draw Chat			FOISPOSITION (A	ame of		DATE	20c. LO	CATION — C	ity or Tow	n, State	
4 Donation 5 Other (Sp	Ft.	t. Lincoln Cemetery 2/1 Bre							ntwood, MD.				
21. SIGNATURE OF SUMERAL S	ERVICE LICEN	HEE MI BY	0 0			ND AODRES			.W.Cha				
hones	.5	100	. le-		F007	G7	2					20737	
iMMEDIATE CAUSE (Final disease or condition resulting in death)	P	tonly one cause	Pertis	PEAL OF	puter	ap	less	tie	des	La V	20.4	interval Between greet and Death	
Sequentially list condition: if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		O) OT 3UG	R AS A CONSEQ	UENCE OF								7 - 2	
PART II. Other significant	conditions	contributing to d	eath but not re	suiting in	the undarivir	g cause g	Iven in I	Part i.	24a, WAS AN	MITTOPSV	24b N	/ERE AUTOPSY FINDINGS	
DID TOBACCO USE							ERTAIN	_	PERFORI	WED?	6	MALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
25. WAS CASE BEFERRED TO M					1 (Check only one,	3 01101	LICIPALITY.	101					
	100	IOSPITAL:			OTHER:								
EXAMINER?			R/Outpatient 2	DOA	A Magelee **-		dd.a.	e / en	40H				
EXAMINER?		☐ Inpatient 2 ☐ E	JURY	DOA	4 - Nursing Hor		oldence (HIBY OCCU	IBED		
EXAMINER? 1 YES 2 MA 27. MANNEB OF DEATH 1 Natural 5 Pen 2 Accident Inve	ding stigation	28e. DATE OF IN (Month, Day,	JURY Year)	28b. TIME INJU	4 Nursing Hor OF 28c, IN. IRY W 1	JURY AT ORK? YES 2		28d. DE\$	CRIBE HOW IN				
EXAMINER? 1 YES 2 MA 27. MANNED OF DEATH 1 Netural 5 Pen 2 Accident Inve 3 Suicide a Cou 4 Homicide dete	ding stigation	28e. DATE OF IN (Month, Day,	JURY Year)	28b. TIME INJU	4 Nursing Hor OF 28c, IN. IRY W 1	JURY AT ORK? YES 2		28d. DE\$4				ite Number,	
EXAMINER? 1 YES 2 MA 27. MANNER OF DEATH 1 Netural 5 Pen 2 Accident Inve 3 Suicide a Cou 4 Homicide dete 29a. CERTIFIER (Check only	ding stigation id not be rmined	Dispetient 2 E E 28e. DATE OF IN (Month, Day, 28e. PLACE OF building, at N: To the best of m	IJURY Year) INJURY — At hon c. (Specify) y knowledge, dea	28b. TIME INJU 10, farm, st	4 Nursing Hor OF 28c, IN. RY M 1 reet, factory, office	URY AT ORK? YES 2	NO end due	28d. DES	TION (Street er Town, State)	nd Number o	r Rurel Roo	ite Number,	
EXAMINER? 1 YES 2 MO 27. MANNED F DEATH 1 Netural 5 Pen 1 Pen 2 Accident 3 Suicide 8 Cou dete 29a. CERTIFIER (Check only one) 2 MEDICAL 29b. SIGNATURE AND TITLE OF	ding stigation id not be rmined NG PHYSICIA EXAMINER: (28e. DATE OF IN (Month, Day. 28e. PLACE OF building, str. N: To the best of month the best of example of exa	JURY Year) INJURY — At honc. (Specify) y knowledge, dearmination end/or in	28b. TIME INJU 1e, farm, st th occurred westigation	4 Nursing Hor OF 28c. IN. WY M 1 1 reet, factory, offix d at the time, date	URY AT ORK? YES 2	NO end due of at the t	28f. LOCA City of	TION (Street er Town, State)	nd Number o	r Rurel Aoi		
EXAMINER? 1 YES 2 M8 27. MANNER OF DEATH 1 Netural 5 Pen 1 Accident 3 Suicide a Cou 4 Homicide dete 29a. CERTIFIER (Check only) 1 CERTIFIER	ding stigation id not be rmined EXAMINER: (CONTINUED IN C	28e. DATE OF IN (Month, Day, 28e. PLACE OF the building, etc.) 28e. PLACE OF the building, etc. 28e. PLACE OF the building, etc. 28e. PLACE OF the building, etc.)	JURY Year) INJURY — At hon c. (Specify) Y knowledge, dea ministion end/or in OF DEATH (ITEM	28b. TIME INJU	4 Nursing Hor OF 28c. IN. WI 1 Prest, factory, office d at the time, date that the my opinion, a	URY AT DRIK? YES 2	end due of ad at the t	28d. DESI 28f. LOCA City of to the cause time, date	TION (Street et r Town, State) re(e) end meni	nd Number of the state of the to the state of the state o	r Rurel Aoi	and menner ee stated.	
EXAMINER? 1 YES 2 NO 27. MANNED DEATH 1 Netural 5 Pen 1 Netural 5 Pen 1 Netural 5 Pen 1 Netural 5 Pen 1 Netural 5 Pen 1 CERTURAL COMMENTAL	ding stigation id not be rmined in EXAMINER: (CARTIFIER CARTIFIER CARTIFIER CARTIFIER CARTIFIER CARTIFIER CARTIFIER CARTIFIER CARTIFIER CARTIFIER CARTIFIER CARTIFIER CARTIFIER CARTIFIER CARTIFIER CARTIFIER CARTIFIER CART	28e. DATE OF IN (Month, Day, 28e. PLACE OF the building, etc.) 28e. PLACE OF the building, etc. 28e. PLACE OF the building, etc. 28e. PLACE OF the building, etc.)	JURY (ber) INJURY — At hon c. (Specify) In y knowledge, dea ministion end/or in the control of	28b. TIME INJU	4 Nursing Hor OF 28c. IN. WI 1 Prest, factory, office d at the time, date that the my opinion, a	JURY AT DRK? YES 2	end due of ad at the t	28d. DESI 28f. LOCA City of to the cause time, date	TION (Street er Town, State)	nd Number of the state of the to the state of the state o	r Rurel Aoi	and menner ee stated.	

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-16 Rev 1/89

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1	-	STATE REGISTRAF
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TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

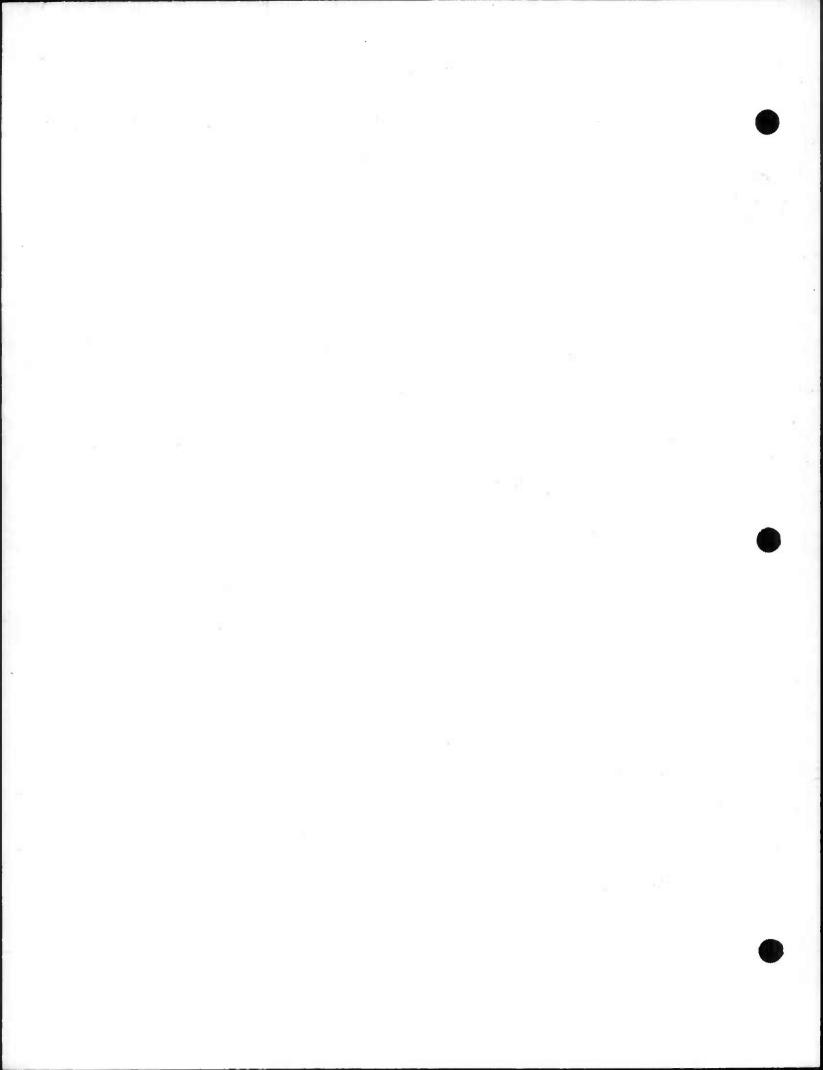
1 - REGISTRAR				ERTIF		OF DEATH	, MILITI	REG. NO				
4 DECEMBRIE MARK (For Allele Long)									3. TIME OF DEATH			
Aline Phyllis May								January 22, 19			9:00 A M	
4. SOCIAL SECURITY NUME	BER	5. SEX	8. AGE (In yrs.	last birthday)	IF UNDER 1 YE			E OF BIRTH nth, Day, Year)		8. BIRTH Countr	IPLACE (State or Foreign	
574-10-3436 1 □ M 2 🔀 F 74 YRS.					MONTHS UM	TS HOURS MIN.			1920		ine	
9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH												
9416 Tobin Circle Potomac Montgomery												
10a. STATE												
Maryland Montgomery Potomac 1 Tyes 2X No												
10e. STREET AND NUMBER	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1											
9416 Tobin Circle 20854 United States												
11. MARITAL STATUS 12. WAS DECEMENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF NISPANIC ORIGIN? (Specify Yes or No. 14. RACE — American Indian										— American Indian,		
3 X Widowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 X NO Specify: Specify:												
White												
(Specify onl	y highest grade	completed)		(Give kind of wille. Do NOT use	ork done durin	g most of working	16	56. KIND OF BU	SINESS/IN	DUSTRY		
Elementary/Secondary (0)-12)	College (1-4 or 5 +)			s Teacher		II de corlo	C -1	1		
17. FATHER'S NAME (First, M	liddle, Last)		[110	me Ecc	MOULT			H1GI.	Sch	001		
Arthur Po		Allyn							,		- 1	
19a. INFORMANT'S NAME (7		RITYII		19b. MAILING	ADDRESS (Str	eet and Number or Rur		Jorda		o Codel		
Eric L. May	V					Circle, P					0054	
20e. METHOD OF DISPOSIT	ION				FDISPOSITION					City or To	0854	
1 X Burlai 2 Cremetic 4 Donation 5 Other	(Specify)		cametery, c	remalory or off	Cemet	ebruary 4 ery		Car:	ibou,	Mai	ne	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00831 ROBERT A. PUMPHY Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501												
23. PART i. Enter the di	islanses, or o	complications that	caused the	deeth. Do n	ot enter the	mode of dying, s	uch ss ce	rdiec or resp	iratory ar	rest.	Approximate	
shock, or he IMMEDIATE CAUSE (Fir	eert tellure.	List only one ceu	se on each lin	10.						1977	Interval Between Onset and Death	
disease or condition		Respira	tory F	ailuro							Onset shd Desth	
resulting in death)		DUE TO	(OR AS A CONS	EOUENCE OF);							
		Aspirat	ion pne	nomi	a						21	
Sequentially list conditi if any, leading to imme-			OR AS A CONS								2+ weeks	
cause. Enter UNDERLY! CAUSE (Disesse or Inju	NG	. Supra B	ulbar I	Palsy							5+ years	
that initiated events		DUE TO	(OR AS A CONS	EOUENCE OF):						J, years	
resulting in death) LAS		d										
PART il. Other significs	nt condition	s contributing to	death but not	resulting in	n the under	ving ceuse given	in Part i.	24s. WAS AN	ALITOPSY	245	WERE AUTOPSY FINDINGS	
						,		PERFORMED?			AMAILABLE PRIOR TO COMPLETION OF CAUSE	
								1 TYES 2X NO			OF DEATN?	
DID TOBACCO U	SE CONTI	PIRLITE TO CA	LISE OF DE	ATLI VE		☐ UNCERTA	INI D				1 ☐ YES 2 X NO	
25. WAS CASE REFERRED TO		KIBOTE TO CA			N (Check only							
EXAMINER?		HOSPITAL:			OTHER:			20 20 CO.				
27. MANNER OF DEATH		28a. DATE OF	INJURY	28b. TIME		Nome 5 X Residenc	_	EŞCRIBE NOW I	NJURY OC	CURED		
	Pending	(Month, De	ay, Year)	INJU	JRY	WORK? YES 2 NO		LOW I	NOONI CO	CONED		
2 Accident Transporter 28a PLACE OF IN HIRV. At home form short forther differ									custo Number			
3 Suicide 8 Could not be determined Suicide determined Suicide												
29a. CERTIFIER (Check only 1 X CERT	IFYING PNYSI	CIAN: To the best of	my knowledge, o	faith occurred	d at the time,	date and place, and d	us to the ci	euse(s) and mer	ner es ata	led.		
CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. One) 2 MEDICAL EXAMINER: On the basic of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)												
1 104												
30. NAME AND ADDRESS OF	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)											
Thomas McNa	ımara,	M.D. 56	02 Shie	elds D	rive.	Bethesda	. Mar	vland	208	L 7	ł	
31. DATE FILED (Month, Day,		32. REGISTRA	R'S SIGNATURE		-7		,	2				
JAN 31 1995 Juli Stavelege Revell												
P. T. T. T. T. T.		77										

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-18 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 27 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transbe filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - STATE REGISTRAR	STATE OF M	ARYLAND / I Cei				EALTH DEAT		MENTA	L HYGIEN REG. NO.	_				
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATN							
	DANA	BRUCE 5. SEX			ARCH		A			AN.	30	95	11:30A M		
	4. SOCIAL SECURITY NUMBER	6. AGE (In yrs. last I		IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.		OF BIRTN h, Day, Year)		Count				
	562-72-4879 9a. FACILITY NAME (If not institution, give st	1 X M 2 F	45	YRS.						. 29,			ifornia		
œ	12512 ROLLING ROAD					TOMN C	R LOCATIO	ON OF DE				UNTY OF DEATH			
DIRECTOR	RESIDENCE OF DECEDENT			FC	-	AC				MOI	ATGC	MERI			
RE	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN C	R LOCAT	ION						10d. INSIDE CITY LIMITS?			
		gomery		Potomac								t TYES 2 T NO			
RA	10. STREET AND NUMBER				101. ZIP CODE						10g. CITI	ZEN OF V	WHAT COUNTRY?		
FUNERAL	12512 Rolling Road 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AR			ED.	12.		0854	EUIODANI	IC ODICIN	10 10 H . W .		States			
	1 Never Married 2 Married	FORCES? 1 [IF YES, GIVE WA	YES 2 XNO	NO II yes, specify Cuber, Maxica 1 ☐ YES 2 📆 NO Specify					an, Puerto Rican, atc.) Bi				E — American Indian, k, Whita, etc.		
ВУ	3 Widowed 4 Divorced	1				l les	rea & IXI NO Specify:						Specify: White		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	:ATION completed)	(Give	ECEDENT'S USUAL OCCUPATION Give kind of work done during most of working					16b. KIND OF BUSINESS/INDUSTRY						
밁	Elementery/Secondary (0-12)	College (1-4 or 5+)			NOT use retired.)										
NO NO	17. FATNER'S NAME (First, Middle, Last)		50	Stock Broker 18. MOTNER'S NAMI						Self E		ed			
	Fred Victor March	etta								Redpai					
) BE	19a. INFORMANT'S NAME (Type/Print)		19b.	MAILING	ADDRESS	(Street a				ber, City or Town					
임	Kim Garton		31	72	Glen	broo	ook St. Riverside, CA 92503								
	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remo	oval from State	20b. PLACE AN	DDATE	OF DISPOS	ITION /Na	ma of		DAT	E 20c. LO	CATION (City or To			
	4 Donation 5 Other (Specify)	-	Metrop	olit	an C	rema	tory	1/3	1/95	Alex	kandr	ia,	Virginia		
	~ E 1	50			1.0	NAME AN	D ADDRES	S OF FAC	Parle	DeVol Drive	Funer	al F	lome		
_	7.01	Jura			Ga	ithe	ersbu	rg.	MD 2	20877					
	23. PART I. Enter the diaeasa, or c ahock, or haert failure. I	omplications that List only one caus	cauaed tha daat e on aach lina.	h. Do r	not anter	the mo	da of dyli	ng, such	aa card	diac or raapi	ratory arm	est,	Approximate interval Batween		
	disease or condition ACUTE NADCOTIC INTOVICATION											Onset and Death			
ı	resulting in death)	P	OR AS A CONSEOU												
Z	Sequentially list conditions,														
CERTIFICATION	if any, leading to immediata cause. Enter UNDERLYING	DUE TO (C	OR AS A CONSEOU	ENCE O	F):							_			
일	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSEQU	ENCE O	n·										
E	resulting in death) LAST				,.								j		
	PART II Other clastificant condition												1		
CAL	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b									WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO					
									-	1 YES 2	□ NO		DF DEATH?		
Σ	DID TOBACCO USE CONTR	PIRLITE TO CAL	ISE OF DEATI	J VE	с П э	ио П	LING	ERTAIN					1 NES 2 NO		
AN	25. WAS CASE REFERRED TO MEDICAL		28. PLACE				UNC	CKIAIN	<u> </u>						
Sic	EXAMINER? X1XXYES 2 NO	HOSPITAL: 1 Inpetient 2	ER/Outpatient 3	DOA	OTHER 4 Nurs		5 Rai	eldence 8	B 🗆 Othe	r (Specify)		_			
27. MANNER OF DEATN 1 Netural (Month, Dey, Veer) 28e. DATE OF INJURY (Month, Dey, Veer) 1 Netural (North, Dey, Veer) 28e. DATE OF INJURY (Month, Dey, Veer) 28e. DATE OF INJURY AT WORK? 28e. DATE OF INJURY AT WORK? 1 VES 2 NO UNKNOWN									URED						
									OWN						
										or Town, State)					
9	29a. CERTIFIER	111 To 11 To 12 To		_											
COMPLETED	CERTIFFING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) end manner as stated. One) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) end manner as stated.														
- 11	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER														
B	Dennis	J. Chut	(e e e)				0.	C.M	E.			AN.	(Month, Day, Year)		
유	30. NAME AND ADDRESS OF PERSON AND	COMPLETED CAUSE	OF DEATH (ITEM	27) (Type,	Print)										
			111 F	eni	n St	ree	t, E	Balt	imo	re, M	aryl	and	21201		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR	'S SIGNATURE												
	FFB 02 1995	Alia David	tox hardall												

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. To hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

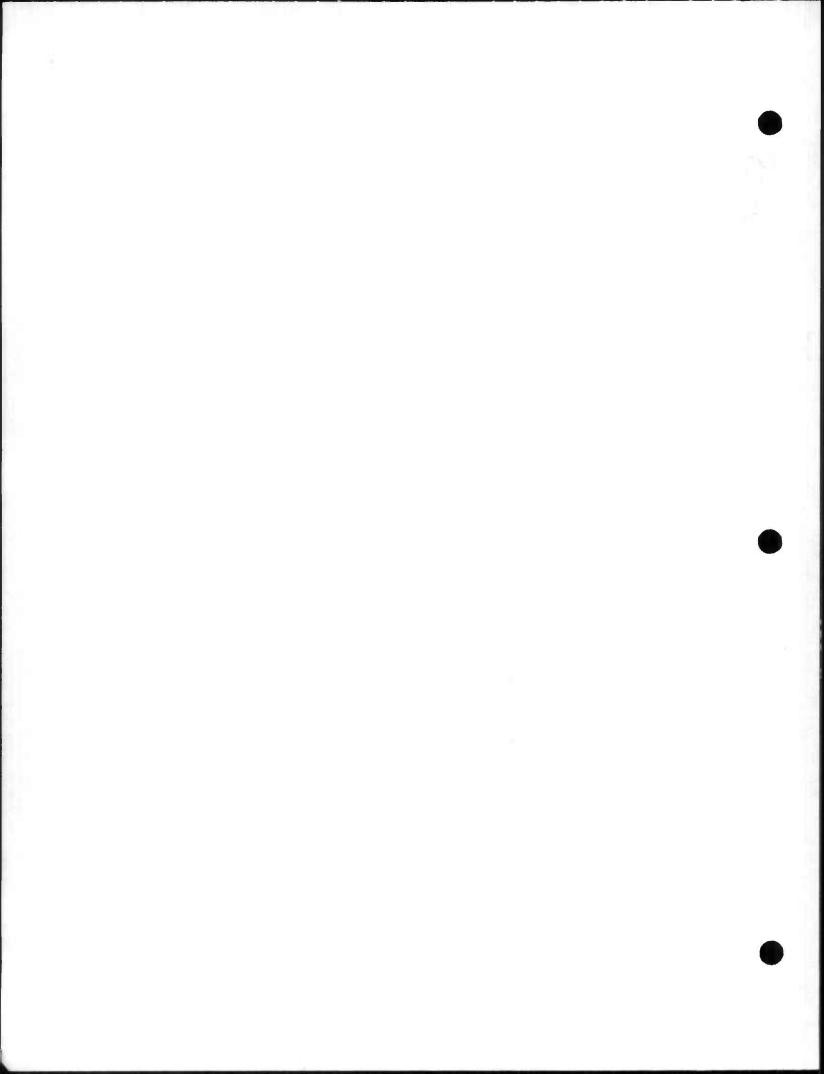
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE CONTROL OF MARTILLAND / DETAILMENT OF DEATH AND MENTAL HTGIENE CERTIFICATE OF DEATH REG. NO.													
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH								YEAR	3. TIME OF DEATH				
_ I	RICHARD LEE	MATTI	MATTIS					MONT.		9:35 p M				
*.	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthday,			IF UNDER 1 YEAR IF UNDER 24 HRS.			7. DATE	JANUARY 27, 199			LACE (State or Foreign		
100	222-26-5727	1 🔀 M 2 🗆 F	52	YRS.	MONTHS DA	YS HOURS	MIN.		th, Day, Year)	142	Denny	isylvania		
١.	9a. FACILITY NAME (If not institution, give street	et end number)			96. CITY, TO	WN OR LOCAT	TION OF S		7, 17		NTY OF DE			
15	THE JOHNS HOPKINS	HOSPITAL			RALT	MORE	CITY	,			N/A	1		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY					<u> </u>				11/1				
H				Y, TOWN OR L						10d. INSIDE CITY LIMITS?				
	Maryland Mon		Ga	ithers	101. ZIP CO			1 X YES 2 NO						
RA	16 Silver Kettle C		20878								AT COUNTRY?			
FUNERAL									M /P M - M	tates				
									Black, Specify	- American Indian, White, etc.				
B√	3 Widowed 4 Divorced	IF TES, GIVE WAR ON DATES			1 YES 2 NO Specify:				*			White		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co		16a. DECE	DENT'S	USUAL OCCUI	PATION	dna	168	. KIND OF BU	BUSINESS/INDUSTRY				
9		College (1-4 or 5+)	Ilfe. Do	o NOT u	se retired.)		ung							
MP		5+	Comp	ute	r Scie	ntist		F	ederal	Gov	ernme	nt		
	17. FATHER'S NAME (First, Middle, Last)					16. MO	THER'S N	AME (First,	Middle, Melden	Sumame)				
H	George Albert Matt	18							ernbac					
2					ADDRESS (Str							20070		
Carole Ann Mattis 16 Silver Kettle Court, Gaithersburg, 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION //Name of DATE 20c. LOCATION CH														
	1 Buriel 2 Cremetion 3 Remove 4 Donetion 5 Other (Specify)	al from State	cemetary, crama	tory or o	ther place)	N (Name or	. 1/	20./05	E 20c. LO	CATION	City or Tow	n, State		
1 Burlel 2 Cremetion 3 Removal from State Cemetery, crametory or other place Metropolitan Crematory 1/29/95 Alexandr 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DeVol Fune									ria,	oral Homo				
	W.1 10	-H.M	2.2		10	East 1	Deer	Park	Drive		erar	nome		
-	Muhael (W.	2000	714		Gai	thersl	ourg	, MD	20877					
	23. PART (. Enter the diseases, or complications that caused the daeth. Do not anter the mode of dying, such as cardiac or respiratory srreat, shock, or heart failure. List only one cause on each line.													
	IMMEDIATE CAUSE (Final disease or condition resulting in death)										Onset and Death			
	resulting in death)	DUE TO (OR	AS A CONSEQUE		fach	-						2 dys		
_					,							2 dys 8 dys 65 dys		
Ö	Sequantisity list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											7		
8	cause. Enter UNDERLYING CAUSE (Disease or injury		Bon	0	Zsero	u +	Zan	92	+			65 000		
E	that initiated events resulting in death) LAST	DUE TO (OR	AS A CONSEQUE	ENCE O	F):	-								
CERTIFICATION	d.		AS A CONSEQUE	96	-5 6	das.	Lonn					2415		
	PART ii. Other algnificent conditions of								24a. WAS AN	AUTOPSY	24b. V	VERE AUTOPSY FINDINGS		
DICAL		Non							PERFOR			WAILABLE PRIOR TO COMPLETION OF CAUSE		
MED								-	t [] YES 2	DENO		F DEATH?		
7	DID TOBACCO USE CONTRIB	BUTE TO CAUS	E OF DEATH	l YE	S 🗆 NO	dZLUN(CERTAI	\Box			- '	HES 200 NO		
X	25. WAS CASE REFERRED TO MEDICAL				TH (Check only						1			
Sic		IOSPITAL:	/Outpetlant 3 🗆	DOA	OTHER:	Home 5 🗆 R	lesidence	8 🗆 Othe	r (Specify)					
PHYSICIAN:	27. MANNER OF DEATH 286. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCC								CURED					
BY	1 Natural 5 Pending 2 Accident Investigation					YES 2	NO	-						
	3 Suicide 8 Could not be	JURY — At home, (Specify)	, ferm, s	treet, fectory,	offica		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
COMPLETE		4 Homicide determined building, etc. (Specify) City or Town, State)												
7				ge, death occurred at the time, date end place, end due to the c										
S S	one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) end manner ee stated.													
w II	286. SIGNATURE AND TITLE OF CERTIFIER	/_				ENSE NU			29d, DAT	ATE SIGNED (Month, Day, Year)				
TO B	1 duns	M	2	>		V	26	255		7/95				
- 1	30. NAME AND ADDRESS OF PERSON WHO C			7) (Type,	Print)	, .								
	SANJEEV	GULA			201	ins to	opl	kuns	Has	ic. Lu	1			
	31. DATE FILED (Month, Day, Year) FFR (19 1005)	32. REGISTRAR'S												
		* Cliffe of Theat	CO. E. C. P. S. S. A. A.	- 11										

DHMH-18 Rev 1/89



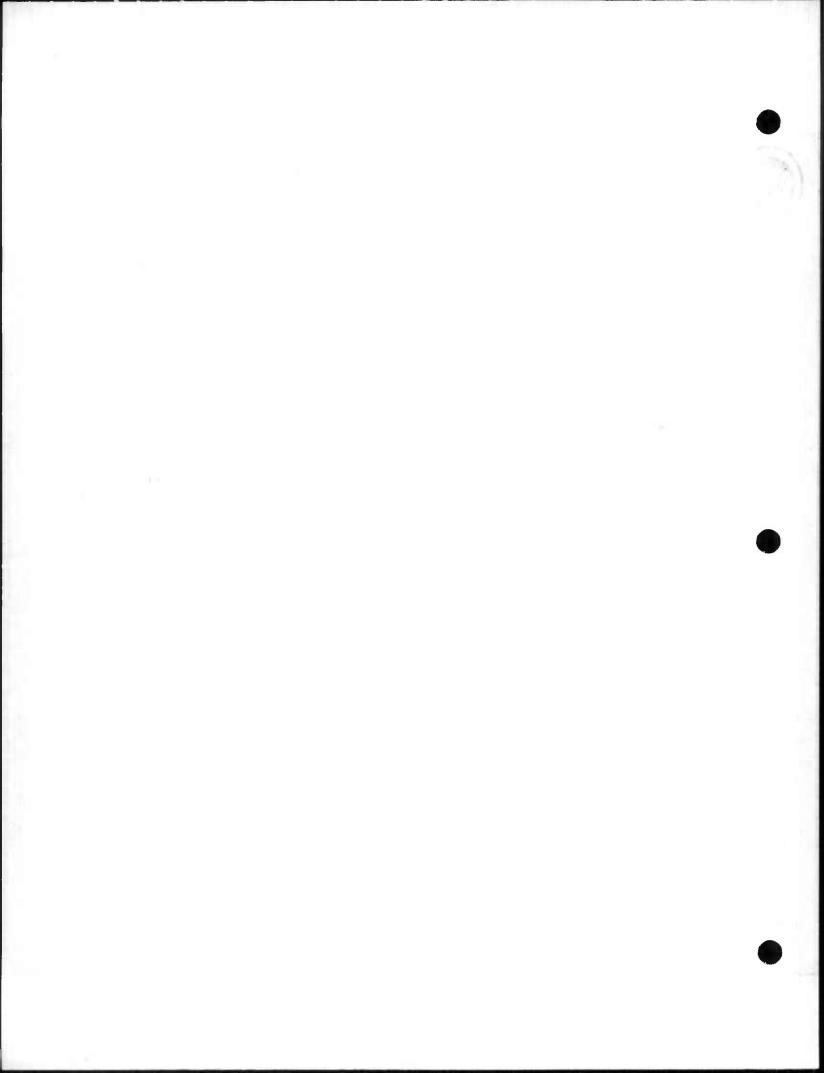
<u></u>		ermit. Progr
20	lysician.	al director, page 5 should be detached for use as the burial-transit permit. Pro-
IMORE, MARYLAND 21215-0020	Page 6 may be retained by the hospital or attending physician.	se as the be
ND 21	hospital or	tached for u
ARYLA	ined by the	hould be de
RE, M	nay be reta	, page 5 sl
IMOM	Page 6 n	director.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a fours after death. Page 6 may be retained by the thosp TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTI DIVISION OF VITAL RECORDS, P.O. BOX 68769

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR		CERTIF	ICATE C	F DEATH	REG. NO	O.				
	1. DECEDENT'S NAME (First, Middle, Last) LEONA	MEADOI	R			2. DATE OF DEATH JAN. 3	0, 19	95 6:00 P.M. M			
ÿ	4. SOCIAL SECURITY NUMBER 577-58-4440	5. SEX 6. AGE 1 □ M 2 🂢 F 9((In yrs. last birthday) YRS.	IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year) FEB. 26,	1904	8. BIRTHPLACE (State or Foreign Country) KENTUCKY			
	9a. FACILITY NAME (If not institution, give at	reet end number)		9b. CITY, TOW	N OR LOCATION OF D		-	NTY OF DEATH			
DIRECTOR	CARRIAGE HILL-BET	HESDA		ВЕТНЕ	SDA		MONT	GOMERY			
E	10a. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR LO	CATION			10d. INSIDE CITY			
	MARYLAND MONT 100. STREET AND NUMBER	GOMERY	ВЕТН	ESDA	10f. ZIP CODE		T	1 YES 2 X NO			
FUNERAL	5215 CEDAR LANE				20814		U.S	. A.			
B	11. MARITAL STATUS 1. Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 X NO	13. WAS I	DECENDENT OF HISPA , specify Cuben, Mexico /ES 2 X NO Specif	NIC ORIGIN? (Specify Youn, Puerto Rican, atc.) y:	es or No—	14. RACE — American Indian, Black, White, atc. Specify: WHITE			
	15. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT'S	USUAL OCCUP	ATION most of working	16b. KIND OF BI	JSINESS/IND	DUSTRY			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT us	e retired.)	ASSISTANT	U.S. G	OVEDN	МЕХІТ			
MO	17. FATHER'S NAME (First, Middle, Last)		PIDITITIO	Idilivi		ME (First, Middle, Maide		FILSIVI			
BE C	ELIHU MEADOR				-11-	ROBERTS	i Gurneme)				
6	196. INFORMANT'S NAME (Type/Print)					Route Number, City or To					
	MADGE KIRBY	l an	115 SO			VER SPRIN					
	1 Burial 2 X Cremetion 3 Remo	oval from State	COMFOR					City or Town, State IA, VA.			
	21. SIGNATURE OF FUNEION SERVICE LIC	ensee Data	100	JOS:	EPH GAWLER	R'S SONS,	INC.				
	, Lucy	1 7 200	1/4	513	O WI. AVE.	N.W. WAS	HINGT	ON, D.C. 20016			
	23. PART I. Enter the diseases, or o shock, or heart fellure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. URIW	ARY T	RACT		ECTION		Approximata Interval Between Onset and Death / Z Hours			
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	ILE	A CONSEQUENCE OF	MMC	00 3/	ADDE	2	16 years			
CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF		01- 80			10 years			
	PART II. Other algnificent condition	contributing to death	but not reaulting i	n tha underly	ring çeuse given in	Part I. 24s. WAS A		24b. WERE AUTOPSY FINDINGS			
DICAL	DIABETE	SMELLI	TUS (T	YPE	I) 404	2015 1 PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
				- 1				1 TYES 2 NO			
AN	DID TOBACCO USE CONTR	RIBUTE TO CAUSE C	OF DEATH YE			N 🗆					
PHYSICIAN: ME	EXAMINER?	HOSPITAL:		QTHER:	lome 5 🗆 Residence	e [] Other (Specific)					
높	27. MANNER OF DEATH	28e. OATE OF INJURY (Month, Day, Year)	26b. TIMI	E OF 28c.	INJURY AT	28d. DESCRIBE HOW	INJURY OCC	CURED			
BY	1 Accident 5 Pending Investigation	(Month, Day, Year)	INS		WORK? YES 2 NO						
	3 Suicide 6 Could not be determined	28e. PLACE OF INJUR building, atc. (Spe	Y — At home, farm, a polity)	treet, factory, o	ffice	28f. LOCATION (Street City or Town, State	end Number)	or Rural Route Number,			
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner es stated.										
шШ	296. SIGNATURE AND TITLE OF CERTIFIER	- /	\cap		29c. LICENSE NUM	men	29d. DATE	E SIGNED (Month, Day, Year)			
10 B	36. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF THE	ATTEN 2D Choo	Priori	D30844		▶FE	B. 1, 1995			
	JAMES F. MCMURRY	, JR, MD 631	8 DEMOCR		D. BETHES	DA, MD. 2	20817				
	31. DATE FILED (Month, Day, Year) FEB 02 1995	32. BEGISTRAR'S SIGN	or Randall								
		0_						DHMH-16 Rev 1/89			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within To hours after death. Page 6 may be retained by the hospital or attending physicial	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriak-to be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 h	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the

											9	0	14/00	
	FOR STATE REGISTRAR		STATE OF N	MARYLAND /	DEPAR	TMEN	T OF H	EALTH DEAT	AND I	MENTAL HYGIE REG. N				
- I	1. DECEDENT'S NAME (First, M.	iddle, Last)	M							2. DATE OF DEATH MONTH	DAY	YEAR	3. TIME OF DEATH	
	JESSIE		M.				IOTT			FEBRUARY	3,19		11:49 Р м	
	4. SOCIAL SECURITY NUMBER 215 68 6287		SEX	8. AGE (In yrs. last	t birthday) YRS.	MONTHS	DAYS	IF UNDER HOURS	24 HRS. MIN.	June 10,	907	MARY!	LAND	
	9a. FACILITY NAME (If not instit	ution, give stree	t and number)			9b. CIT	Y, TOWN C	R LOCATIO	ON OF DE		9c. COUNTY OF DEATH			
OR	ALLEGANY COU	NTY NU	RSING H	3110		(CUMBI	ERLAN	ID.		ALLEGANY			
5	RESIDENCE OF DECE	DENT 0b. COUNTY											OIM12	
DIRECTOR	10a. STATE 16 Naryland 1				OR LOCAT	TON				- 1	10d. INSIDE CITY LIMITS? 1 YES XXNO			
AL	10e. STREET AND NUMBER					101	. ZIP CODE			10g. CIT	IZEN OF WI	HAT COUNTRY?		
FUNERAL	947 Bedford	Stree	t				1 2	2/502	•		USA	1		
S	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No — 14, RA										14. RACE	- American Indian,		
											100000000000000000000000000000000000000	White, atc.		
m 3 - Widowed 4 Divorced												WK	ite	
핃	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)											DUSTRY		
	Elementary/Secondary (0-12	9	College (1-4 or 5 +)							,			
MP	12			n ou	rewif	e				own				
8	17. FATHER'S NAME (First, Midd							-		ME (First, Middle, Maide	n Sumame)			
BE	Ross David		tte	4						Ross				
199. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Rouge Number, City or Town, State, Zip Code) 541 Beacon Knoll Lane, Fort Mill, St. 29715									5					
	20a. METHOD OF DISPOSITION 12 Burlal 2 Cremation	3 🗆 Ramova	I from Stata	20b. PLACE A	ND DATE (of DISPO	SITION (Na	me of	- 1 /	DATE 20c. I	OCATION —	City or Tow	n, Stata	
	4 Donation 5 Other (Sc 21 MONATURE OF FUNERAL 3		NEE.	Dunset	llen	oru	u ro	UR F	eb C), 1995CW	noenla	ציו, ציו	<i>y</i>	
	Dones	as F	2 H	alu)	Ho	ler	Chap	eli	of the Hi Highway,	Us Me	ortua	ky 21502	
	23. PART i. Enter the dise	eses, or con	plications the	ceused the de	ath. Do r								Approximete	
	shock, Dr hee	rt feilure. Lis	t Dnly one cau	se on each line.				,			,		interval Between Onset and Death	
	iMMEDIATE CAUSE (Finel disease or condition		10-1	118-11	1								Onset and Death	
	resulting in death)	a	DUE DO	(OR AS A CONSEC	DUENCE OF	7):	real	u					10 5/1-	
,														
ERTIFICATION	Sequentially list condition if any, leading to immedia		DUE TO	OR AS A CONSEC	UENCE OI	j:							1	
S	ceuse. Enter UNDERLYING	a /												
Ē	CAUSE (Disease or injury that initiated events		DUE TO	OR AS A CONSEC	DUENCE OF	7):								
E	resulting in death) LAST	d												
O	PART II. Other aignificent	oppditions o	antalhusta a ta	d-ath hat										
PHYSICIAN: MEDICAL	the same	Conditions of	J1	death but not re			noeriying	ceuse g	liven in	Part I. 24a, WAS A	N AUTOPSY ORMED?	1	WERE AUTOPSY FINDINGS WAILABLE PRIOR TO	
ă	the land	arow.	L H	(1)	lin	(6)				1 YES	2 NO		COMPLETION OF CAUSE OF DEATH?	
E											,	1	T YES 2 NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN									1 🗆					
5	25. WAS CASE REFERRED TO N EXAMINER?		OSPITAL:	26. PLAC	E OF DEAT	H (Check								
YSI	1 TYES 2 NO			ER/Outpatient 3	□ DOA			o 5 □ Ra	aldence	6 Other (Specify)				
H	27. MANNER OF DEATH		26a. DATE OF (Month, Da		28b. TIM	E OF URY	26c. INJ WO	URY AT RK?		26d. DESCRIBE HOW	INJURY OC	CURED		
ВУ	1 Natural 5 Per 2 Accident Inve	eatigation				M		'ES 2 [NO					
8		uld not be armined	26a. PLACE Of building,	F INJURY — At hor atc. (Specify)	ma, farm, s	treet, tac	tory, office			261. LOCATION (Stree City or Town, Stat	t and Number e)	r or Rural Ro	ute Number,	
E														
COMPLET										to the cause(a) and m				
S	one) 2 MEDICA	L EXAMINER: (On the basis of as	amination and/or li	nvestigatio	n, In my	opinion, d	eath occun	ed at the	time, data and place,	and due to th	he cause(s) :	and manner as stated.	
	296. SIGNATURE AND TITLE OF	сентинен	i i					29c. LICE	NSE NUN	IBER	29d. DAT	E SIGNED (Month, Day, Year)	
) BE	//	6000	ny					n	1480	55	1	2-5	-55	
일	30 NAME AND ADDRESS OF D	EDOON WALO O	A				_			1			13	

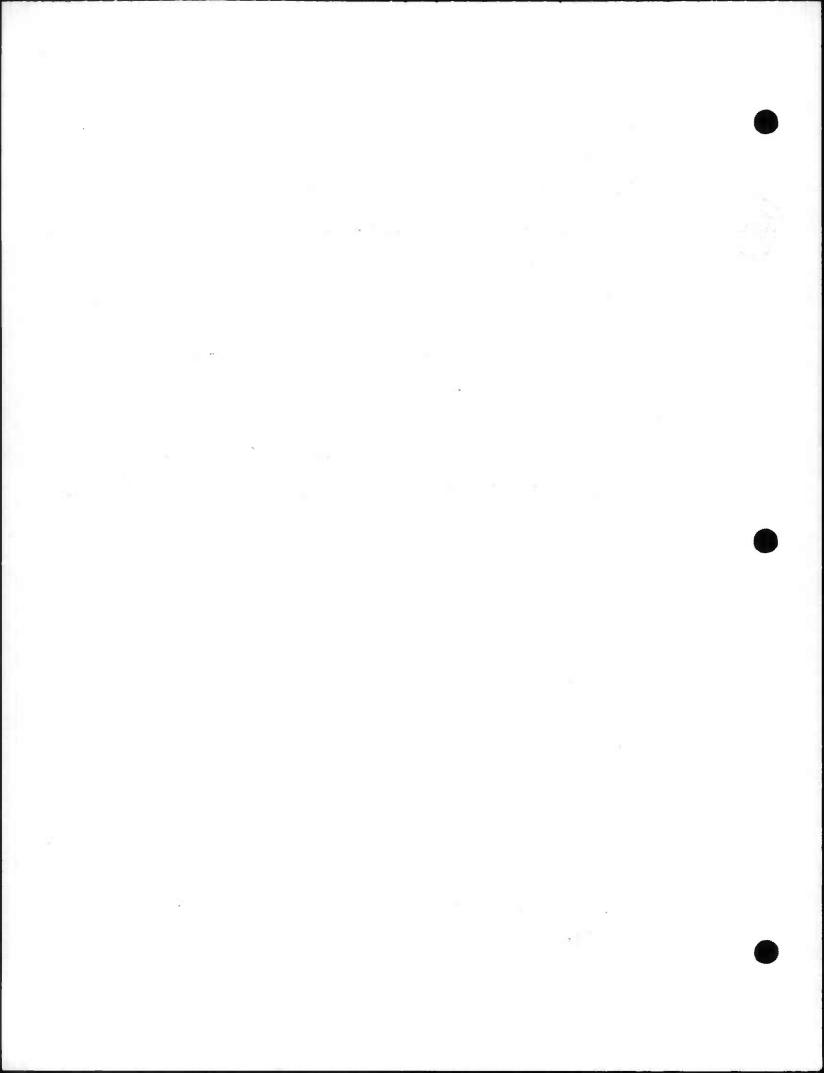
32. REGISTRAR'S SIGNATURE

0 6

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DR. ROBUSTIANO J. BARRERA/MEMORIAL HOSPITAL MEDICAL BLDG, / CUMBERLAND, MD

21502



TO BE COMPLETED BY FUNERAL DIRECTOR

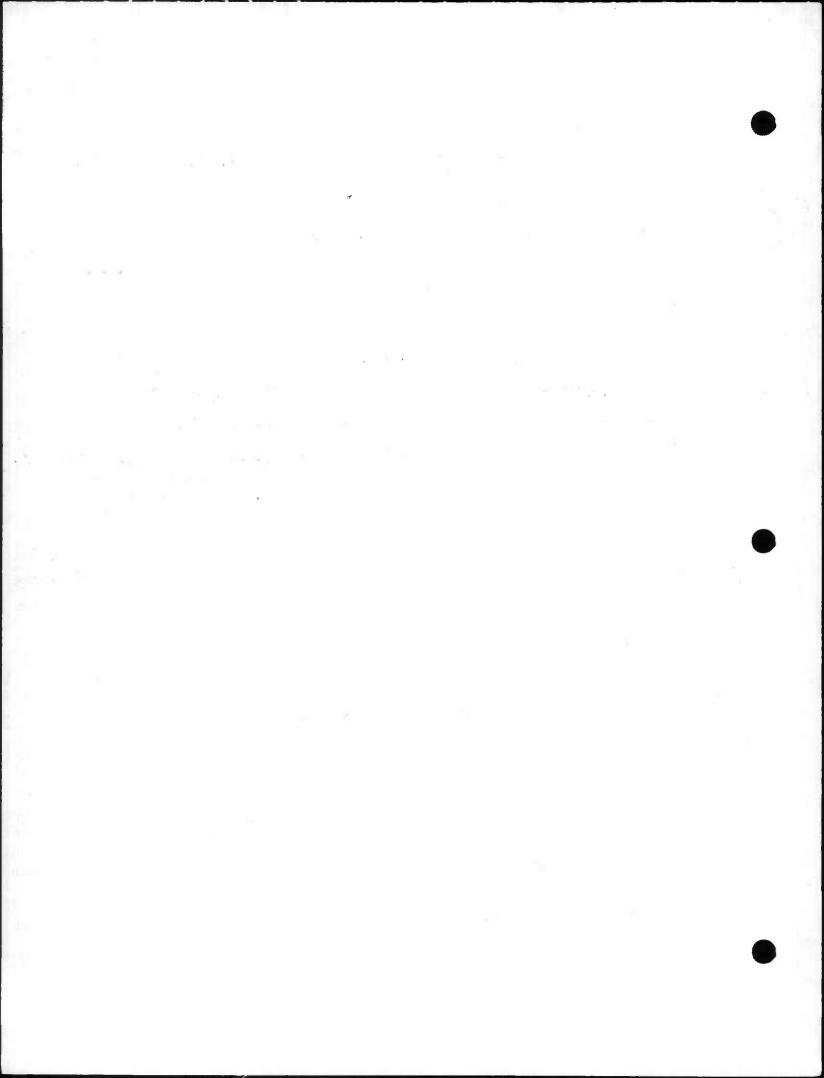
FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - STATE REGISTRAR		OIMIE OF I	C		ICATE OF	DEATH	MENIAL	REG. NO	_		
1. DECEDENT'S NAME (First,	Middle, Last)						2. DATE O	F DEATH			3. TIME OF DEATN
ANNA Ch	ristin	a	MURI	RAY			MONTH 2	4		995	5:25 A M
4. SOCIAL SECURITY NUMB		5. SEX	8. AGE (In yrs. I	asl birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE O	E BIRTH		6. BIRTH	IPLACE (State or Foreign
216-22-5807		1 🗌 M 2 🔯 F	95	YRS.	MONTHS DAYS	HOURS MIN.	Dec.	14,1	899	Count	ryland
9a. FACILITY NAME (If not ins	stitution, give stre	et and number)	AT		9b. CITY, TOWN	OR LOCATION OF D				NTY OF D	
MEMORIAL HO	SPITAL	& CENTE			CUMBER	LAND			ALLI	EGANY	7
10a. STATE	10b. COUNTY			10c CIT	Y, TOWN OR LOCA	TION				1000	10d. INSIDE CITY
Maryland	Α.	llegany		100.01	Mt. Sav						LIMITS?
10e. STREET AND NUMBER	n.	TTEKRITA				f. ZIP CODE			100 CIT	175N OF V	1 TYES 2 NO
15933 Fou	ndarr D.					21545			log. Cit		
11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. A	RMED	13 WHS DE	CENDENT OF NISPA	NIC OBIGINS	(Casalt, Va	ar Na		5.A.
1 Never Married 2 3 Widowed 4 Divor	Married	FORCES? 1 IF YES, OIVE W	YES 2	NO	If yes, s	pecify Cuban, Maxic 3 2 X NO Speci	an, Puerto Ri	can, atc.)	I OF NO-	Speci	— American Indian, k, White, atc. My: Vhite
15. DECE	EDENT'S EDUCA	TION	16a, (DECEDENT'S	USUAL OCCUPATI	ON	16h. I	KIND OF BU	SINESS/IN		AITT CO
(Specify only Elementary/Secondary (0-	highest grade c	College (1-4 or 5 -		(Give kind of the Do NOT us	work done durina m	osl of working					
12	,	0	"	Home	emaker				Dome:	stic	
17. FATNER'S NAME (First, Mil	ddle, Last)			240214	J-14 CAL	18. MOTHER'S N	AME (First, Mi				
Charles Mc	Millan						ssa P				
19s. INFORMANT'S NAME (Ty				196. MAILING	ADDRESS (Street	and Number or Rural				p Codel	
Jack Murra	V					342 Oldt					
20a. METNOD OF DISPOSITION	ON		20b. PLAC	EANDDATE	OF DISBOSITION /A	ama ol	DATE	200 10	CATION	City or To	Cinto
1 D Buriel 2 Cremation 4 Donation 5 Donation		ral from State	cemetery o	rematory or o	ther plecel	tery Feb	8 05	Trans	a et bu	ony or 10	I and a
21. SIGNATURE OF FUNERAL		NSEE	/	7011000	22. NAME A	ND ADDRESS OF F					
1 521	u R.C	K) uni	1					Durst			
23. PART I. Enter the di					57 Fr	ost Aven	ue Fro	ostbu	g, l	laryl	and 21532
IMMEDIATE CAUSE (Fin disease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter UNDERLY!! CAUSE (Disease or injuit that initiated events resulting in death) LAS1	a. ona, b. lilate NG ry	DUE TO	(OR AS A CONS	EOUENCE O	F):						Interval Between Onset and Death
PART II. Other significes	nexti	à ;						24s. WAS AN PERFOR	MED?	24b	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO	MEDICAL				26. P	LACE OF DEATH (C	heck only one)	}			
EXAMINER?		HOSPITAL:	ER/Outpatient	3 🗆 DOA	QTHER:	ne 5 🗆 Residence					
27. MANNER OF DEATH		28a. DATE OF	INJURY	26b, TIM	E OF 28c. IN	JURY AT		(Specify)	NJURY OC	CURED	
	Pending	(Month, D	ay, Year)	INJ	M 1	YES 2 NO					
2 Destates —	nvestigation	28a. PLACE O	F INJURY At I	home, ferm,	street, factory, offi		26f, LOCAT	TION (Street)	and Numbe	r or Rumi f	Route Number,
	Could not be letermined	building,	etc. (Specify)				City or	Town, State)			
						and place, and du					a) and manner as stated.
29b. SIGNATURE AND TITLE	OF CERTIFIER		1			29c. LICENSE NU	IMBER		29d. DAT	E SIGNED	Month, Day, Year)
H	VIII	2110	h			D28910)	7/	-192
30. NAME AND ADDRESS OF	PERSON WNO	COMPLETED CAUS	SE OF DEATH (IT	EM 27) (Type	, Print)	DEUSIO				-/-	3/12
CURTISS MERR	ICK M.I	D., MEMO	RIAL HO	OSPITA	AL MEDIC	AL BLDG.	, CUM	BERLA	ND, 1	6D 2	21502
31. DATE FLEBONDOS	1995	32. REGISTRA	R'S SIGNATURE	all							

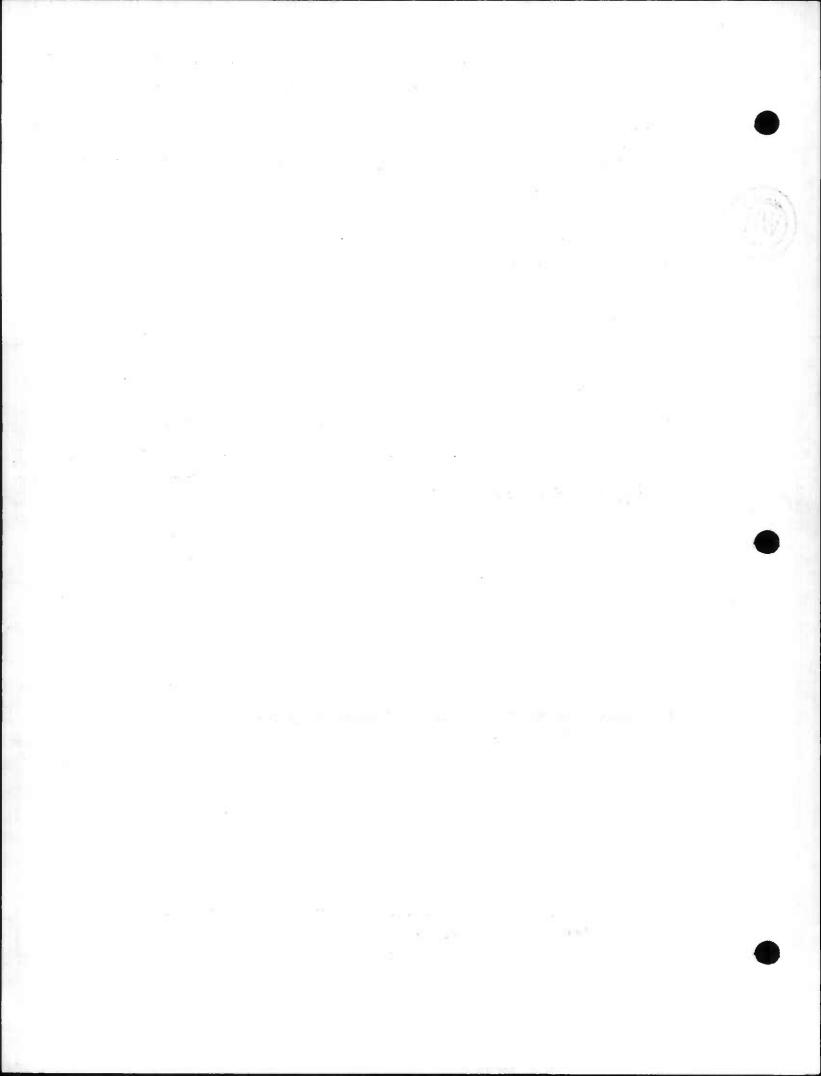
IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO						
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	AV	95ª	3. TIME OF DEATH	2		
	Edward Michael	Monahan			T		1			P M		
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (in 1 X M 2 1 F 7 8	yrs. last birtnday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		Country	,	lgn .		
	213 10 9670 9a. FACILITY NAME (If not institution, give stre	25 - 70	THS.	A) (0) TO (0)		JAN. 13,						
Œ					OR LOCATION OF DE	EATH		NTY OF O				
읽	LIONS MANOR NURSI	NG HOME		CUMB	<u>ERLAND</u>		AL	LEGAN	Υ			
DIRECTOR	10a. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR LOCA	TION				10d. INSIDE CITY LIMITS?			
		EGANY	F	ROSTBUR					1 TES 2XXNO	0		
FUNERAL	100. STREET AND NUMBER 19104 NATIONAL HI	ICHWAY NU		10	21532			J.S.A	HAT COUNTRY?			
N	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U	I C ADMED	12 49 05		NIC ORIGIN? (Specify Yes						
F	1 Never Married 2 Married	FORCES? 1 T YES	2 NO	If yes, s		n, Puarto Rican, atc.)	s or No—	Black	- American Indian, White, atc.			
BY	3 Widowed 4 Divorced	6/28/45 - 11/	29/45	' '	S Z (ANO Specin)	r:		Specif	WHITE			
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION 1	6a. DECEDENT'S	USUAL OCCUPAT	ON ost of working	16b. KIND OF BU	SINESS/IN	DUSTRY				
Ë	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	se retired.)								
M	17. FATHER'S NAME (First, Middle, Last)		SAI	LES		GAS CO						
ö					mes average	ME (First, Middle, Maiden	,					
BE	EDWARD MONAHAN 19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street		GARET MICH. Route Number, City or Tow		n Corde)				
2	ROSE MONAHAN					Y, NW, FRO			D 21532			
	20a. METHOD OF DISPOSITION	20b. P	LACE AND DATE	OF DISPOSITION /				City or Ton				
	1 Burial 2 Cremation 3 Ramon 4 Donation 5 Other (Specify)	0 = 1	MICHAE	L CEM.	FEB. 4	, 1995 FRO	STBUI	RG, M	D 21532			
	21. SIGNATURE OF FUNGRAL SERVICE LICE	NSEE /	1		ND ADDRESS OF FA	L HOME, P.	٨					
	1/ mulou	JIX	DUMAN			., FROSTBU		m 21	532			
	23. PART I. Enter the diseases, or co	emplications that caused t	the deeth. Do r	not enter the m	ode of dying, auc	h aa cerdlec or reap	iretory ar	reat,	Approximate			
	shock, or heart fellura. List only one cause on each line. IMMEDIATE CAUSE (Finel Onest and Death											
	disease or condition reculting in deeth)	DUE TO (OR AS A C	e Am	est					Monai			
		DUE TO (OR AS A C	ONSEQUENCE O	F):		1						
NO	Sequentially list conditione, b.	DUE TO (OR AS A C	3 COSO	ue Co	irdiova	seular D	isla	sl	year	4		
YATI	if any, leading to immediate cause. Enter UNDERLYING		ONGEQUENCE O	. ,.					0			
띮	CAUSE (Disease or injury that initiated evente	DUE TO (OR AS A C	ONSEQUENCE O	F):						-		
CERTIFICATION	resulting in death) LAST											
5	PART II. Other significent conditions	contributing to deeth but	not reguiting	In the underlyle	og ceuse given in	Part I. 24a, WAS AN	AUTORCY	1 245	WERE AUTOPSY FIND	MNOS		
EDICAL	Multion				Α /	france 1 - YES	DAREDO	240.	AVAILABLE PRIOR TO COMPLETION OF CAU)		
	TISHEXCON.	Jon factor	L, Mou	740	and sure	TI YES :	X NO		OF DEATH?			
2	DID TOBACCO USE CO	ONTRIBUTE TO C	AUSE OF	DEATH Y	ES IT NO	- IZI			1 YES 2 NO			
PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL				LACE OF DEATH (Ch							
Sic		HOSPITAL: 1 Inpatient 2 ER/Outpati	lent 3 DOA	OTHER: 4 X Nursing Ho	me 5 🗆 Rasidenca	6 Other (Specify)						
PHY	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	26b. TIM	E OF 28c. IN	JURY AT ORK?	26d. DEŞCRIBE HOW	INJURY OC	CURED	-			
BY	1 X Natural 5 Pending 2 Accident Investigation				YES 2 NO							
	3 Suicide 6 Could not be datarmined	28a. PLACE OF INJURY — building, atc. (Specify	At home, farm,	atreet, factory, offi	СВ	281, LOCATION (Street City or Town, State		r or Rural A	loute Number,			
E												
COMPLETED		IAN: To the best of my knowled										
S	2 MEDICAL EXAMINER	On the basis of examination a	and/or investigation	on, in my opinion,	death occured at the	time, deta and place, as	nd due to t	ha cause(s)	and manner as state	ed.		
BE (296. SIGNATURE AND TITLE OF CERTIFIER	il. m			29c. LICENSE NUI				(Month, Day, Year)			
10	way 12	W/A			D11443)	▶ U2	2-02-	77			
	W.C. Spiggle, M.D.	0 1			Dr Cumi	perland M	D ′	21502				
	31. OATE FEED (Moth), 64.1995			Secon	Dr., Culii	Jerranu. M	<i>U</i> • 2	2002				
	1995	32. REGISTRAR'S SIGNAT	dall									

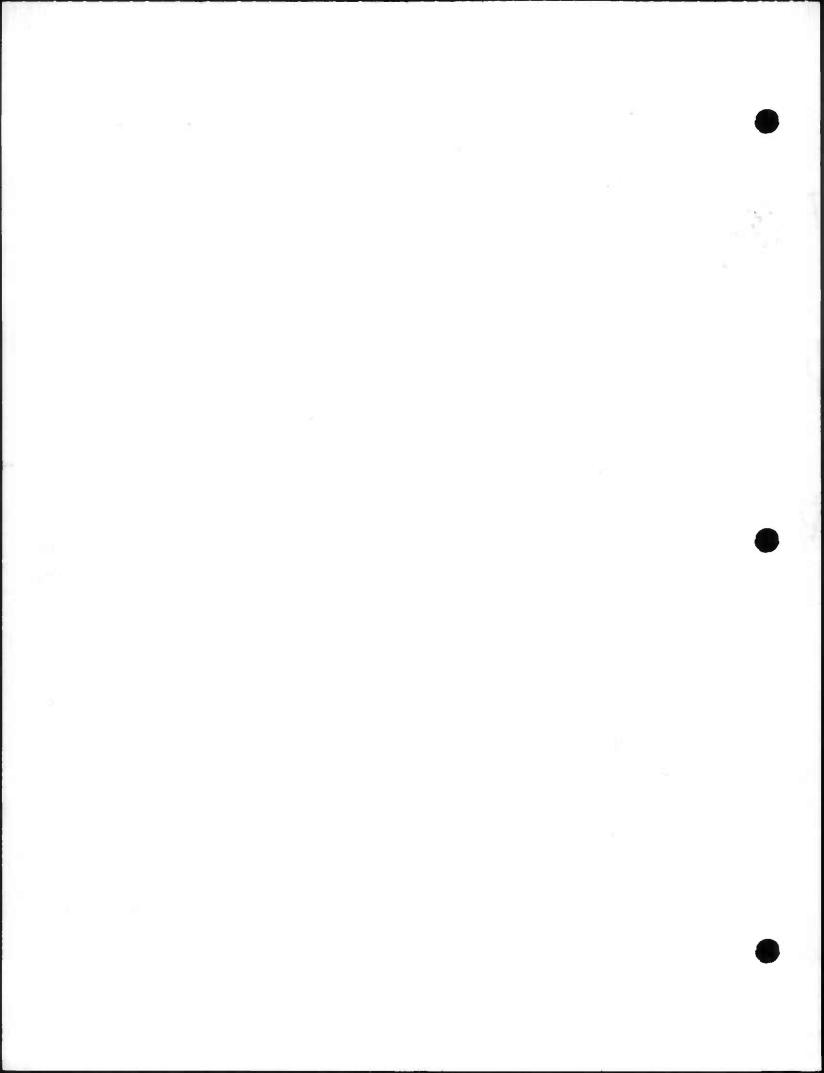


TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physicial	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-the filled within 70 hours after cheath with the State Dear of Health and Mental Hordine horizon in hurial commandor or embodi	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN:	TO THE FUNERAL DIRECTOR: After this certific, he filed within 72 hours after death with the St	IMPORTANT: If Item 28 is marked, or it

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last) KATHERINE PEAR				_	2. DAT	RUARY		995	TIME OF DEATH 6:51 AM		
		8. AGE (1 1 M 2\(\) F 83	In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	JUL:	oth, Pay Year 9	6. M	BIRTHPLA COURTY! ARYL	AND		
POR	98. FACILITY NAME (If not institution, give stree MEMORIAL HOSPITAL	it and number)		96. CITY, TOWN C	LAND	EATH		9c. COUNTY ALLEG		Н		
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS?											
	MARYLAND ALLE	EGANY	CUM	BERLAND	ZIP CODE					YES 2 NO		
FUNERAL	720 COLUMBIA AVE.	O COLUMBIA AVE. 21502 U.S.A.										
B⊀	3 Not Wildowed 4 Divorced IF YES, GIVE WAR OR DATES A 1 YES 2 NO Specify: WHITE											
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade col Elementary/Secondary (0-12)	TION mpleted) College (1-4 or 5 +)	16a. DECEDENT'S U (Give kind of wo life. Do NOT use COSMETIC	ork done during mo retired.)	st of working		66. KIND OF BUS					
OME	17. FATHER'S NAME (First, Middle, Last)		COSMETTO	IAN / SA		_	t, Middle, Maiden :		ALES			
BE C	CHARLES SULUMAN JUHNSTON ANNA SHAW 199 INFORMANT'S NAME (Row/Right)											
2	DORIS COCHENOUR				nd Number or Rural AVE. CUM					502		
	20 METHOD OF DISPOSITION 1 Al Aburlai 2 Cremation 3 Ramova 4 Donation 5 Other (Specify)	ol from State RC	PLACE AND DATE OF	EMETERY	me of Y FEB 6	1995	CUMBI	ERLAND				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MERRITT—ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND											
	23. PART I. Enter the diseasee, or con shock, Dr heert failure. Lis	nplications that caused it only one cause on a	the deeth. Do no	ot enter the mo-	de of dying, aud	h as ca	rdiec or respi	ratory arrest	t,	Approximate Interval Batween		
	IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)		Cardior	espitato	a are	1				30 kmh.		
_		DUE TO (OR AS A	Cardio V CONSEQUENCE OF, Complete	beau	the					30 wint		
ATIO	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING		CONSEQUENCE OF)									
CERTIFICATION	CAUSE (Disease or Injury that initiated eventa resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF)									
AL C	PART II. Other significent conditions of		ut not resulting in	the underlying	g ceuse given in	Part I.	24a. WAS AN			RE AUTOPSY FINDINGS		
PHYSICIAN: MEDIC		AU.					1 TYES 2	*	DF	MPLETION OF CAUSE DEATH? YES 2		
AN: N	DID TOBACCO USE CONTRIE				UNCERTAI	N 🗆				123 2 3 2 3		
SICI/		IOSPITAL:		OTHER:	a 5 🗆 Rasidenca	6 Ott	her (Specify)					
	27. MANNER OF DEATH 1 Natural 5 Pending	26s. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	OF 28c. INJI	URY AT RK?		ESCRIBE HOW IN	JURY OCCUR	RED			
ED BY	2 Accident Investigation 3 Suicide S Could not be datarmined	28e. PLACE OF INJURY building, atc. (Speci	— At home, farm, strify)		ES 2 NO	281. LC	OCATION (Street at by or Town, State)	nd Number or	Rural Route	Number,		
PLET	29a. CERTIFIER (Check only	N: To the beat of my knowle	edge, death occurred	at the time, date	and place, and due	to the c	ause(a) and man	ner an atated.	_			
COMPLETED		On the basis of examination			eath occured at the	time, da		dua to the c				
TO BE	sele 1	Stal	ung		29c, LICENSE NU	19	P/	Fel	h. 3	onth, Day, Year)		
	30. NAME AND ADDRESS OF PERSON WHO C	· HALM	105 30	Sch Sch	ley st	. 6	umbe	ela	div	. 95 Md:		
	31. DATE FILED (Month, Day, Year) FEB 0 6 1995	REGISTRAR'S SIGNA	Mardall		0							



IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	IMP
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.) pe #
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burland	6
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicial	[P 0]
SALLINORE, INCOLOS, T.O. BOARD SIZING TEAM SIZING S	0

DIVISION OF VITAL RECORDS, P.O. BOX 68760

sched for use as the burial-tra

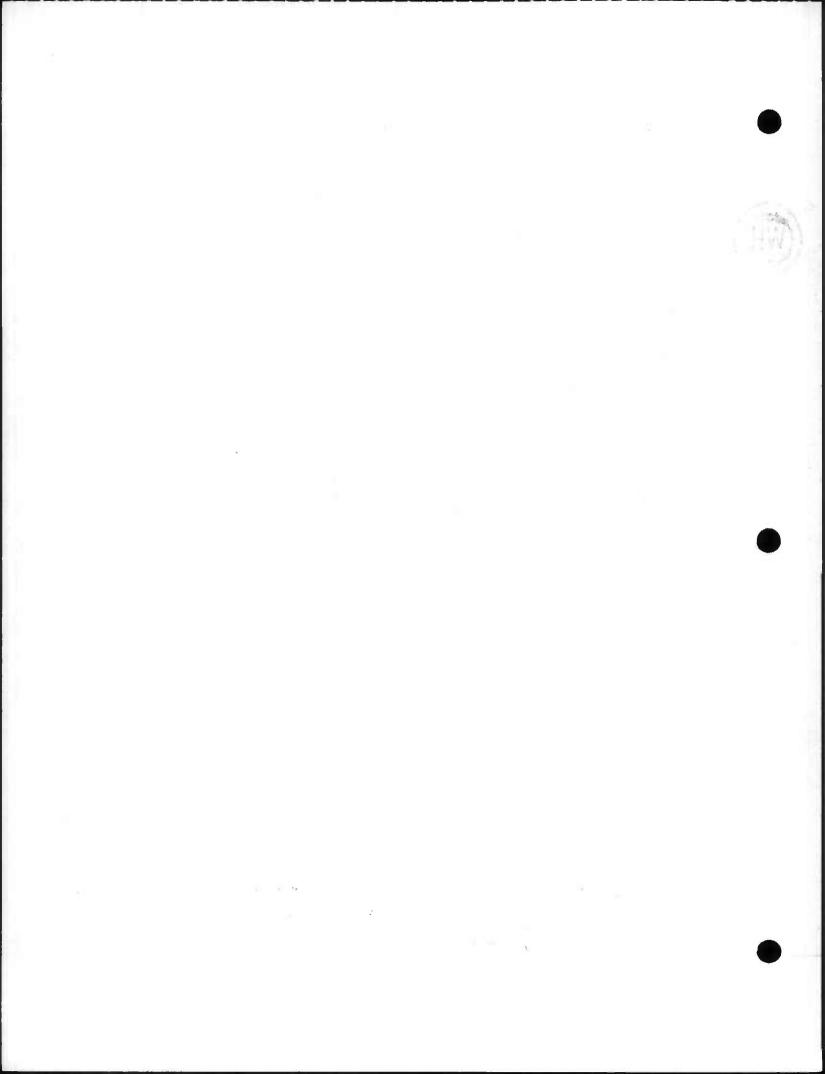
BALTIMORE, MARYLAND 21215-0020

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FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR		CE			OF DEATH		REG. NO.	_			
	1. DECEDENT'S NAME (First, Middle, Lest)						2. DATE OF	DEATH			3. TIME OF DEAT	Н
	HELEN		M:	ILLE	R	Janua	irv 3		YEAR 995	11:50	рΜ	
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. las	t birthday)	IF UNDER 1 YE		7. DATE OF	BIRTH		8. BIRTH	PLACE (State or Fo	ngien
	220-38-0073	1 □ M 2 🏋 F	78	YRS.	MONTHS DA	YS HOURS MIN.	oct 2	1, 19	16	Countr	WV	
	9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY, TO	WN OR LOCATION OF				INTY OF D	EATH	
DIRECTOR	Memorial Hospital				Cuml	perland			A1:	legar	ıy	
EC	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Υ	*	10c. CIT	Y, TOWN OR L	OCATION					10d. INSIDE CITY	
DIA	MD Alle	gany		Cun	mberlar	nd					LIMITS?	NO
	10e. STREET AND NUMBER					101. ZIP CODE			10g. C/1	IZEN OF V	WHAT COUNTRY?	
FUNERAL	47 Maple Street					21502			USA	A		
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED	13. WAS	DECENDENT OF HISPA	ANIC ORIGIN?	Specify Yes	or No-	14, RACE	E — American India k, White, etc.	in,
ΒY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE V	MAR OR DATES			YES 2X NO Spec		uri, sic.j		Speci	tty:	
	15. DECEDENT'S EDU	CATION	180 05	CEDENTIO	USUAL OCCU	DATION!					white	
	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(Gi	ve kind of Do NOT u	work done durin	g most of working	100. KI	IND OF BUS	SINESS/IN	DUSTRY		
PL	12	College (1-4 or 5		mema.	ker		0	wn Ho	me			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	H-10				18. MOTHER'S N						
BE C	Emerson Carl W	otring				Oda M	vers					
TO B	19a. INFORMANT'S NAME (Type/Print)		198	. MAILING	ADDRESS (St	eet and Number or Rura		City or Town	n, State, Zi	p Code)	-	
F	Christian L. Sou	lsby	80	7 Wi	nifred	Road; Cur	mberlar	nd, M	D 2	1502		
	20a, METHOD OF DISPOSITION 1X Burlal 2 Cremation 3 Ram	oval from Stata	20b. PLACE A cemetery, crei		OF DISPOSITIO	N (Neme of	OATE		CATION -	City or To	wn, State	
	4 Donation 5 Other (Specify)				netery		02/03	Aur	ora,	WV		
	21. SIGNATURE OF FUNERAL SERVICE LIC	2 /	200	/1		pelli Fur		iome				
	Comes 7	KICO	upll	1	Cum	perland, N	4D 215	502				
	23. PART Enter the diseases, or shock, or haert fellure.	complications the	t caused the de	eth. Do	not enter the	mode of dying, su	ch ss cardla	c or reepi	ratory ar	rest,	Approxima	
	IMMEDIATE CAUSE (Finel	: h 1	ade on each line		001		PD.	1.	1.	. 13	Opset and	
	disease or condition resulting in death)	a. HCV	ronce	a = 1	Corl	25 mg	101	LVY.	' (iop	11)4 N	200
		DUE TO	OR AS A CONSEC	OUENCE O	F): Y) (9	-C.			10	
NO	Sequentisity flat conditions,	b	Stower	41,6		Szon	enn	7				
CERTIFICATION	If sny, lesding to immedista cause. Enter UNDERLYING	002 10	(OR AS A CONSEC	DENCE O	r):							
FIC	CAUSE (Diseese or injury that initiated events	c. OUE TO	(OR AS A CONSEC	DUENCE O	Pin >		4					
E	resulting in desth) LAST	. C	: how	win	V I	se fres	Són	w				- 1
2		0									-	
DICAL	PART ii. Other significent condition	s contributing to	death but not re	esuiting	In the under	lying c‡use given i	n Pert I. 24	PERFOR		24b.	AMILABLE PRIOR	ro
EDIC							1	YES 2	NO		OF GEATH?	AUSE
2	DID TOD ACCOUNT CONT	DIDITE TO 01									1 TES 2 T	ю
PHYSICIAN:	DID TOBACCO USE CONT	KIBUIE IO CA			TH (Check only		IN L					
S	EXAMINER?	HOSFITAL:			OTHER:							-
¥	27. MANNER OF DEATH	28a. DATE OF	ER/Outpatient 3	28b. TIM		Home 5 Residence	6 Other (S		N ILIBA UC	CHRED		-
	1 Natural 5 Pending	(Month, D	lay, Year)	IN	IURY	WORK?	Zou. DESCR	IIDE HOW I	NJOH! OC	CONED		
BY	2 Accident Investigation 3 Suicide 8 Could not be	26a. PLACE C	F INJURY — At hor	me, farm,			28f, LOCATI	ON (Street a	ind Numbe	r or Rural F	Route Number,	
	4 Homicide determined	building,	stc. (Specify)				City or 1	Town, State)				
E	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of	my knowledge de	eth occurs	ad at the time	date and place, and du	a to the assumed	(a) and man		4 - 4		
COMPLETED	(Check only one) 2 MEDICAL EXAMINE) and manner as st	ated.
	29b. SIGNATURE AND TITLE OF CERTIFIES		-		-	29c. LICENSE NU					-	
띪		XX							Zyd. DAI	2 1	(Minth, Doy, Year)	
임	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAU	SE OF DEATH (ITEN	1 27) (Type	, Print)	D 233	5/1			-//	11) .	-
	Dr. Q. Zaman, Jol					, Cumber1	and. M	D 2	1502			
	31. DATE FILED (Month, Cay, Year) FEB 0 3 1995		AR'S SIGNATURE			,	,					\neg
	TED 03 1995	Ilia Lev	elin handa	Д								



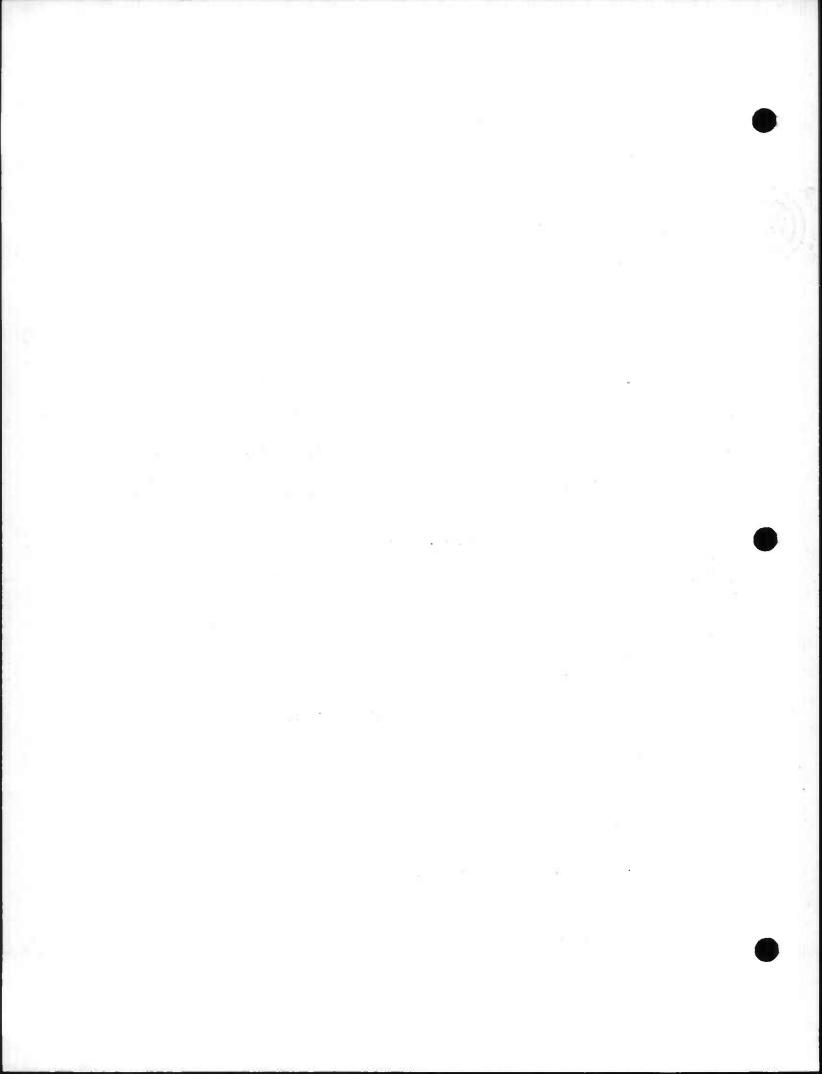
FOR

TO BE COMPLETED BY FUNERAL DIRECTOR

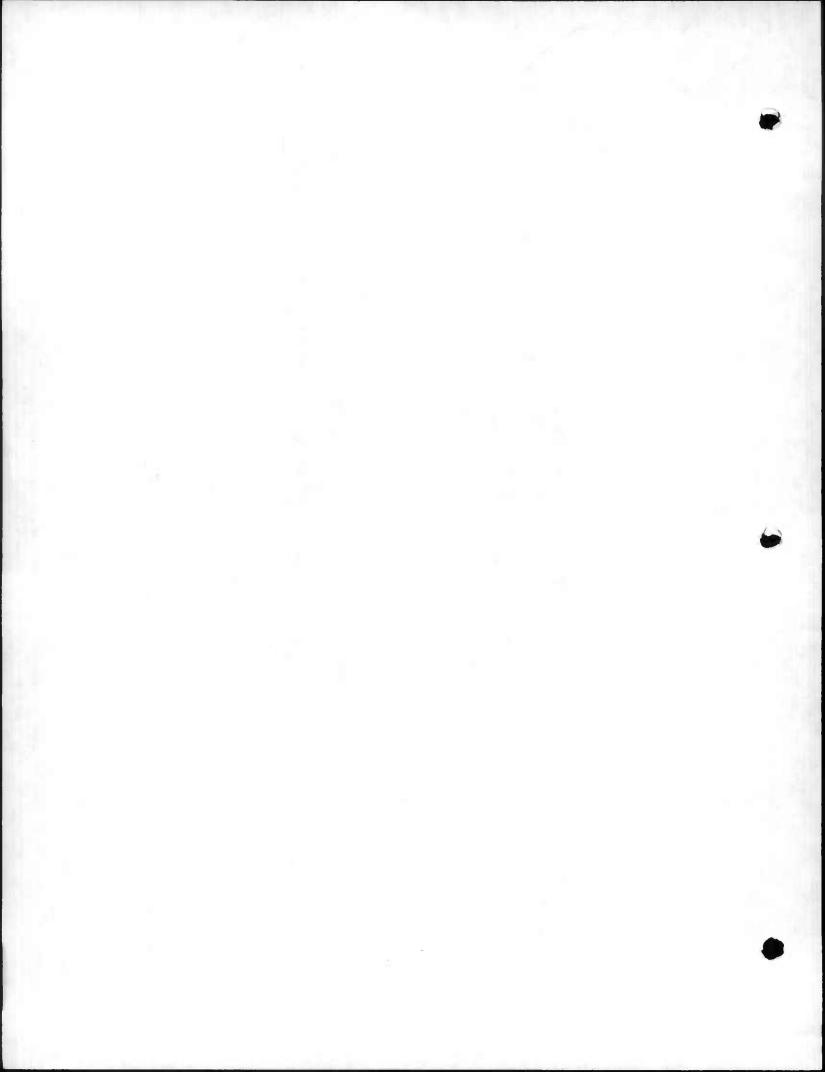
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR	SIAIE UF MANY	CERT					WENIAL HY	G. NO.			
1. DECEDENT'S NAME (First, Middle, Last)						-	2. DATE OF DE	ATH			3. TIME OF DEATH
Warren	Euge	ne	N	1i11e	r		Februa	ry l	, 19	995	9:15 P M
4. SOCIAL SECURITY NUMBER	- 70	(In yrs. last birthda		R 1 YEAR	IF UNDER		7. DATE OF BIF	TH	Ť	8. BIRTH	PLACE (State or Foreign
212-38-5325	1 ₹ M 2 □ F 5	5 YRS	MONTHS	DAYS	HOURS	MIN.	(Month, Day, ULY 29,	, 193	39	Mary	
9e. FACILITY NAME (If not institution, give s	treet end number)		9b, CIT	Y, TOWN O	R LOCATIO	ON OF DE		_		NTY OF D	EATH
12140 National Pi	.ke		Gra	ntsv	ille				Garr	cett	
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY											
			NWOT ,YTK		ON						10d. INSIDE CITY LIMITS?
Maryland Garret	, (GE	ants								1 YES 2 NO
12140 National Pi	ke			101.	ZIP CODE	215	36		-	SA	HAT COUNTRY?
1 Never Merried 2 Nerried 3 Widowed 4 Divorced	12. WAS OECEDENT EVER FORCES? 1 M YES IF YES, GIVE WAR OR VICTNAM	DATES	13	WAS DECI If yes, spe 1 YES	city Cube	n, Mexica	IIC ORIGIN? (Spe n, Puerto Ricen,	cify Yes o	r No—	14. RACE Black Specif Whili	— American Indian, , White, etc. fy:
15. DECEDENT'S EDU		18a. DECEDENT	'S USUAL	OCCUPATIO	N .		16b. KIND	OF BUSIN	NESS/IND		
(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NO	of work done use retired.	during mos	t of workin	9					
12 th		Fore	man				Tire	Sho	p		
17. FATHER'S NAME (First, Middle, Last)	11						ME (First, Middle,				
William Edward Mi	TIer				Scl	nril	1.a Bern	adea	n G1	lotfe	elty
190. INFORMANT'S NAME (Type/Print) Donna K. Miller							Number, City				21536 sville, MD
20e. METHOD OF DISPOSITION	Τ					=, r					
120 Buriel 2 Cremetion 3 Reme		b.place and da antsvii				2-4	1.			City or To	
21. SIGNATURE OF FUNERAL, SERVICE LIC				NAME AN	-	_	1	OL GI	0071		, 1,117
1 × 20.4	XI.)	N	lewman	n Fur	nera	1 Homes	, P.	A.		
23. PART I. Enter the diseases, or o	O Jeuman	0	1.1	55 M	ain S	St	Grants	wi 11	0 N	ID 2	21536
shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. DUE TO (OR AS	ng Ca	Week	υ					and y and		Approximate Interval Between Onset and Death IO MINTES
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	•	A CONSEQUENCE									
that initiated events resulting in death) LAST	d.	A COMBEQUENCE	0.0								
PART II. Other significant condition	s contributing to death	but not resultin	g in the u	nderlying	cause g	iven in	Part I. 24a. 1	WAS AN AL	TOPSY	246	WERE AUTOPSY FINDINGS
DID TOBACCO USE (CONTRIBUTE TO	CAUSE	E DEA	TH YI	:	NO	_ ''	YES 2			MMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
25. WAS CASE REFERRED TO MEDICAL	CONTRIBUTE TO	CAUSE C	, DLA		$\overline{}$	NO EARTH (Chi	ack only one)				
EXAMINER2	HOSPITAL:	tostlent 3 🗆 DO4	OTHE		\ /						
27 MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. 1	TIME OF	28c. INJU	PRY AT		6 Other (Spec		URY OCC	CURED	
2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJUR building, etc. (Sp	IY — At home, farr	-			, 110	281. LOCATION City or Town	(Street end	d Number	or Rural R	loute Number,
200 CERTIFIER											
(Check only	CIAN: To the best of my kno) end menner ee stated.
296. SIGNATURE AND TITLE OF CERTIFIER	9 Schnit	trus			29c. LICE	DE NUM	18ER 333		≥ 2 ≥ 2	IGNED 3	Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF D	EATH (ITEM 27) (7)	rpe, Print)	land) 1	ud	Zan	2		 	
31. DATE FILED (Month, Day, Year)	32' REGISTRAR'S SIG	NATURE AL					0 100		_		

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the functal director have 5 should be functioned by the burnal transpose for the burnal transpose filled in by the functal director have 5 should be filled by the burnal transpose filled in by the functal director have 5 should be filled burnal transpose filled in the burnal transpose filled in the filled BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760



CERTIFICATE # 95-04759
SEE
CERTIFICATE #



BALTIMORE, MARYLAND 21215-0020	ained by the hospital or attending physician.	hould be detached for use as the burlal-transit perm
BALTIMORE, M.	hours after death. Page 6 may be reti	ed in by the funeral director, page 5 s or removal.
AL RECORDS, P.O. BOX 68760	e law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician,	has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit perm Dept, of Heatth and Mental Hygiene prior to burlal, cremation, or removal.

notified at once.

pe

must

medical examiner

the

traumatic event,

other

10 injury,

any

r this certificate hi

DIRECTOR: After the hours after death v

FUNERAL within 72 h

TO THE HOSPITA
TO THE FUNERA
De filed within 7.

0

marked,

49

28

PHYSICIAN:

BY

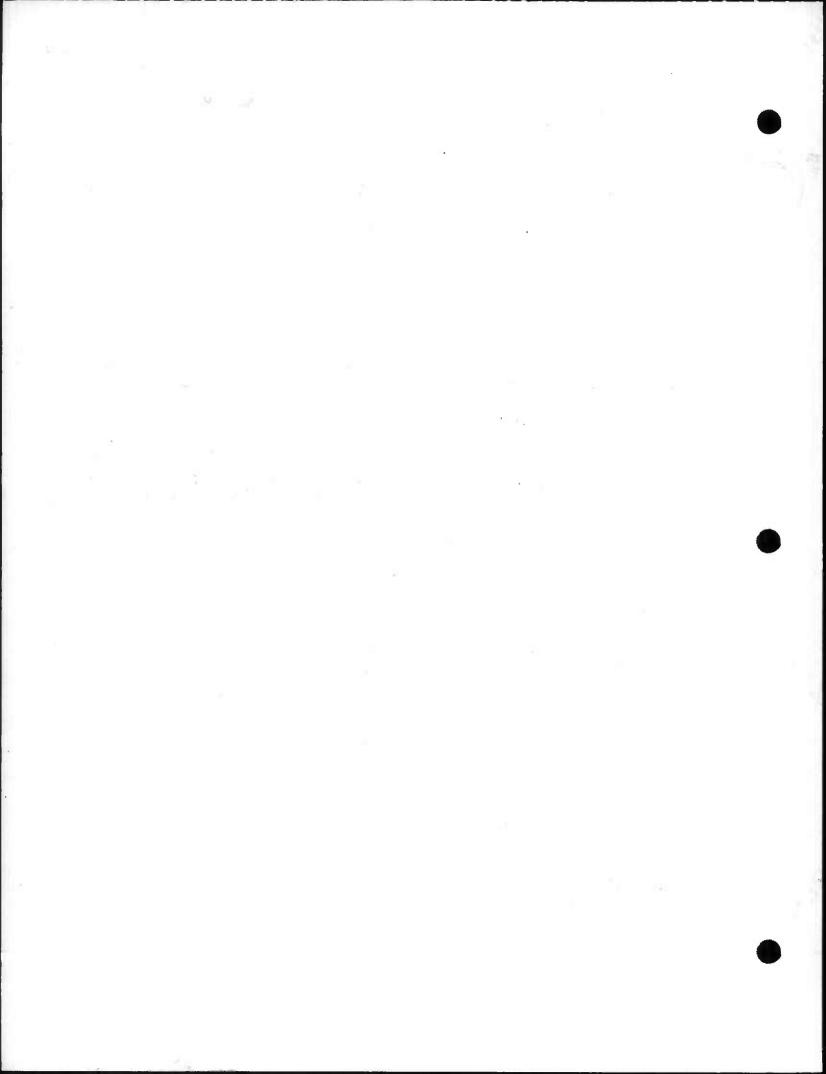
COMPLETED

BE 2

ended # 18 MRT Hmene FOR 1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MRAZIK FRANK Stephen 9:25 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS DAYS 1 🔀 M 2 🗌 F 160-28-0463 YRS May 30. Pennsylvania 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR North Hampton Manor Nursing Home Frederick Frederick RESIDENCE OF DECEDENT 10e STATE 10b, COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Washington Keedysville 1 YES 2 XNO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3541 Trego Mountain Road 21756 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married ВУ Specify: 3 Widowed 4 Divorced White 1952-1956 ED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) E Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Steel Worker 12 Steel Factory 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname, Michael Mrazik Rose BE Nachta Nochta t9a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Margaret Mrazik (Wife) Same as #10 20s. METHOD OF DISPOSITION
1 □ Burlel 2 □ Cremation 3 □ Ramoval from State
4 【X Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Cernetery, crematory or other place) Bethesda. MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. M00827 933 Gist Ave, Silver Spring, MD 20910 23. PARTA. Enter the diseases, or complications that caused the deeth. Do not enter tha mode of dying, auch as cardiec or respiratory arrest, Approximata shock, Dr heart failura. List Dnly Dna ceuse Dn eech lina. interval Betwe IMMEDIATE CAUSE (Final Onsat and Death disease or condition Arteriosclerotic cardiovascular disease resulting in death) abeles mellitus CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE Gargrene 1 TES 2 NO OF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 - Residence 8 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO Investigation 2 Accident 28s. PLACE OF INJURY — At home, ferm, streat, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be 4 Homicide 29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) and manner ea stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end piece, and due to the ceuse(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ninth Ave 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Julia Davidson Rano JAN 30



DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARY	BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician	ined by the hospital or attending physicia
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transfer within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	rould be detached for use as the burial-tr
IMPORTANT: Il item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	fled at once.

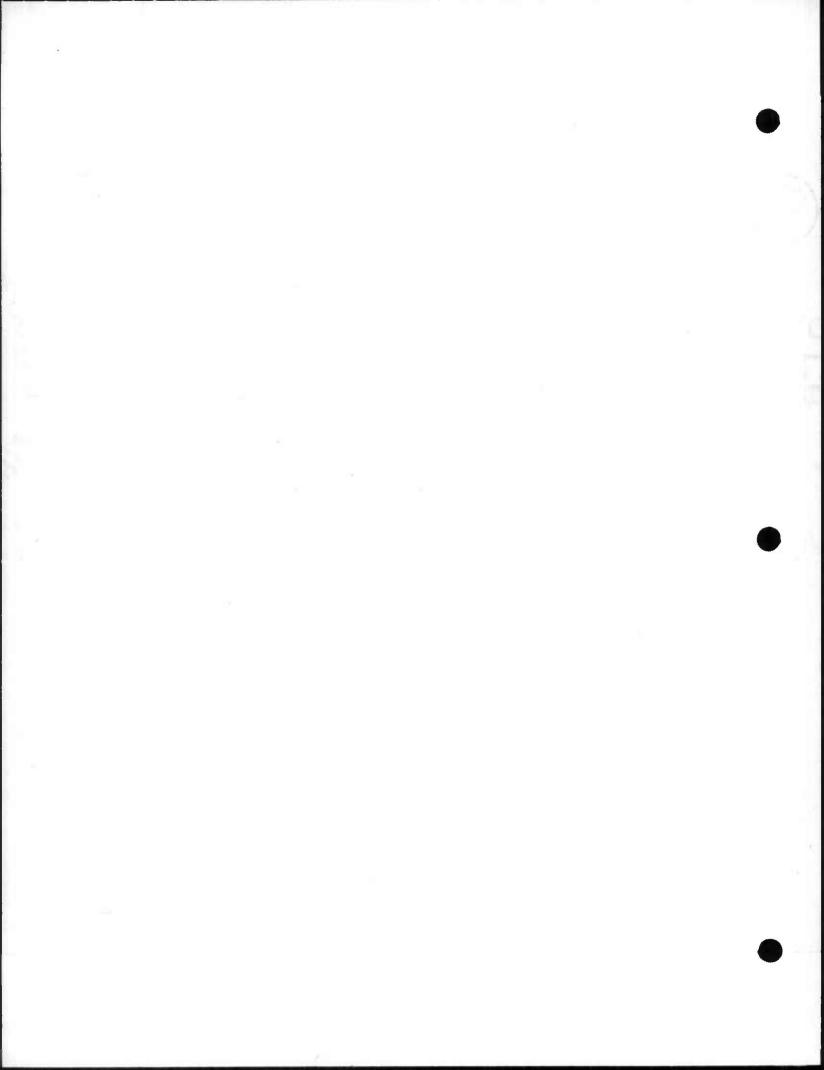
FOR

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICHE

1 - STATE REGISTRAR		SIAIL OF R	C	ERTIF	ICATE (OF DEATIN		MENIA	REG. NO	_			
1. DECEDENT'S NAME (First,	Middle, Last)							2. DATE	OF DEATH		10	3. TIME OF DEAT	Н
	Doris	Ai	leen	M	ills			MONT	uarv 2		YEAR	11:19	рм
4. SOCIAL SECURITY NUMB	BER	5. SEX	6. AGE (In yrs. I	ast birthday)	IF UNDER 1 YE	AR IF UNDER	R 24 HRS.	7. DATE	OF BIRTH	9. 1	6. BIRTH	IPLACE (State or Fo	
220-14-2969		1 □ M 2🏋 F	6	9 YRS.	MONTHS DA	YS HOURS	MIN.		il 28,	1025	Counti		
9a. FACILITY NAME (If not in:	stitution, give atre	et and number)			9b. CITY, TO	WN OR LOCATI	ON OF D		11 20,		NTY OF D	ryland	
13769 Travi	ilah Ro	ad			Roci	kville	110						
RESIDENCE OF DEC	EDENT				ROCI					MIG	ontg	omery	
10a, STATE	10b. COUNTY			10c. CIT	Y, TOWN OR LO	CATION						10d. INSIDE CITY	
Maryland	M	ontgomer	У		Rocl	kville						1 YES 2 X	NO
10e. STREET AND NUMBER						10f. ZIP COD	E			10g. CIT	ZEN OF V	WHAT COUNTRY?	
13769 Travil	lah Roa	d				20	850			Unit	ted S	States	
11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. A		13. WAS	DECENDENT (OF HISPA	NIC ORIGIN	f? (Specify Yes	or No-	14. RACE	E — American India k, White, etc.	in,
1 Never Married 2 X		IF YES, OIVE W		,,,,		YES 2 NO			nican, etc.)		Speci	Hy:	
15 DECI	EDENT'S EDUCA	TION	1.00									White	
(Specify only	y highest grade co	mpleted)			WORK done during		ng	16b	. KIND OF BUS	SINESS/INC	DUSTRY		
Elementary/Secondary (0- 1.2	-12)	College (1-4 or 5 +	,		•				0				
17. FATHER'S NAME (First, Mi	iddle I net)		п	omemal	ker				Own				
Carleton		rrows S	r			16. MOT			Middle, Maiden				
19a. INFORMANT'S NAME (7)		LIOWS, L		05 MAII 1910	40000000	100			Rober				
Donald H. Mi					ADDRESS (Str							2 20250	
20g, METHOD OF DISPOSITI					Travil								
1 Buriel 2 Cremation 4 Donation 5 Other	n 3 🗆 Ramovi	al from State	cemetery, c	rematory or o	of Disposition ther place) Lan Cht	rnest	/2/9 own.	5 DAT		CATION —			
21. SIGNATURE OF FUNERAL		ISEE	Presi	byter.	lan Chi	E AND ADDRE	emet	ery	Dar:	nesto	own,	Marylan	d
m -	1 6	77	75		Home	Rock	vill	e, In	1c., 3	00 W.	Mor	rey Fune ntgomery	Ave
1 hich	ule	FIM		348	Kock	cville	, Ma	rylan	nd 20	850-2	2805	J 4	
23. PART I. Enter the disabook, or he	seasea, or con	mplicationa the	coused the d	leeth. Do r	not enter the	mode of dy	ing, auc	h as card	fiec or reapi	ratory arr	eet,	Approxima	
IMMEDIATE CAUSE (Fin		or only one cau	so on aach iii	ra.								Interval Be Onset and	
disease or condition resulting in death)	→	Acut	e Leuke	emia								DNE YET	R.
			OR AS A CONSI		*							4 mor	1749
Sequentially liet condition	D.		odyspla			ome							
If any, leading to immed	dieta	DUE TO	OR AS A CONSE	EOUENCE OF	ጉ :								
CAUSE (Disease or Injur		DUE TO	OR AS A CONSE										
that initiated events resulting in death) LAST		DOE 10	ON AS A CONS	EUUENCE OI	-):								
	d.												
PART II. Other significan	nt conditione	contributing to	deeth but not	reaulting i	n the underi	ying ceuse (givan in	Part I.	24s. WAS AN		24b.	WERE AUTOPSY FIN	
									PERFOR			AVAILABLE PRIOR 1 COMPLETION OF C	
								_	T TES 2	ZENO		OF DEATH?	
DID TOBACCO US	SE CONTRI	BUTE TO CA	JSE OF DEA	ATH YE	S II NO	□ UNC	ERTAII	\Box				1 TES 2 XN	°
25. WAS CASE REFERRED TO					N (Check only o			1					-
EXAMINER?		IOSPITAL:	ER/Outpatient	3 DOA	OTHER:	dome 6X Be	oldonos	e 🗆 Other	· Caratti				
27. MANNER OF DEATH		28a. DATE OF	INJURY	28b. TIM	E OF 28c.	INJURY AT	Islaence		CRIBE NOW II	VJURY OCC	URED	-	\dashv
	Pending nvestigation	(Month, Da	y, Year)	INJ	URY 1	WORK? YES 2	NO	2000,000					- 1
2 Sulphda	Could not be	28a. PLACE OF	INJURY — At h	ome, farm, s	treet, factory, c	offica		28f. LOC	ATION (Street a	nd Number	or Rural R	loute Number	-
	istarmined	building,	etc. (Specify)					City	or Town, State)				
29a. CERTIFIER 1 K CERTI	IFVINO PNYSICIA	N: To the heat of	my knowledge d	landh annum									
(Check only		N: To the best of a										\d	
(Check only one) 2 MEDIC	CAL EXAMINER:					n, death occur	ed at the	time, data		d due to th	e cause(s)) and manner as sto	sted.
(Check only	CAL EXAMINER:					29c. LICE	ed at the	time, data		d due to th	e cause(s)	(Month, Day, Year)	-
(Chock only 1 CHITI	OF CENTURES	On the besis of ax	emination and/or	Investigatio	n, In my opinio	29c. LICE	ed at the	time, data		d due to th	e cause(s)		-
(Check only 1 CHITI	OF CERTIFIED PERSON WNO	On the besis of ax	E OF DEATN (ITE	Investigation	n, in my opinio	29c. LICE	ed at the NSE NUM	time, data	and place, and	29d. DATE	signed	(Month, Day, Year) 'Y 30,199	95
(Chock only 1 K CERTION) 2 MEDIC 24 SIGNATURE ANOTITLE	OF CENTIFICATION OF CEN	COMPLETED CAUS	E OF DEATH (ITE, 9707	EM 27) (Type,	n, in my opinio	29c. LICE	ed at the NSE NUM	time, data	and place, and	29d. DATE	signed	(Month, Day, Year) 'Y 30,199	95



TO BE COMPLETED BY FUNERAL DIRECTOR, M

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

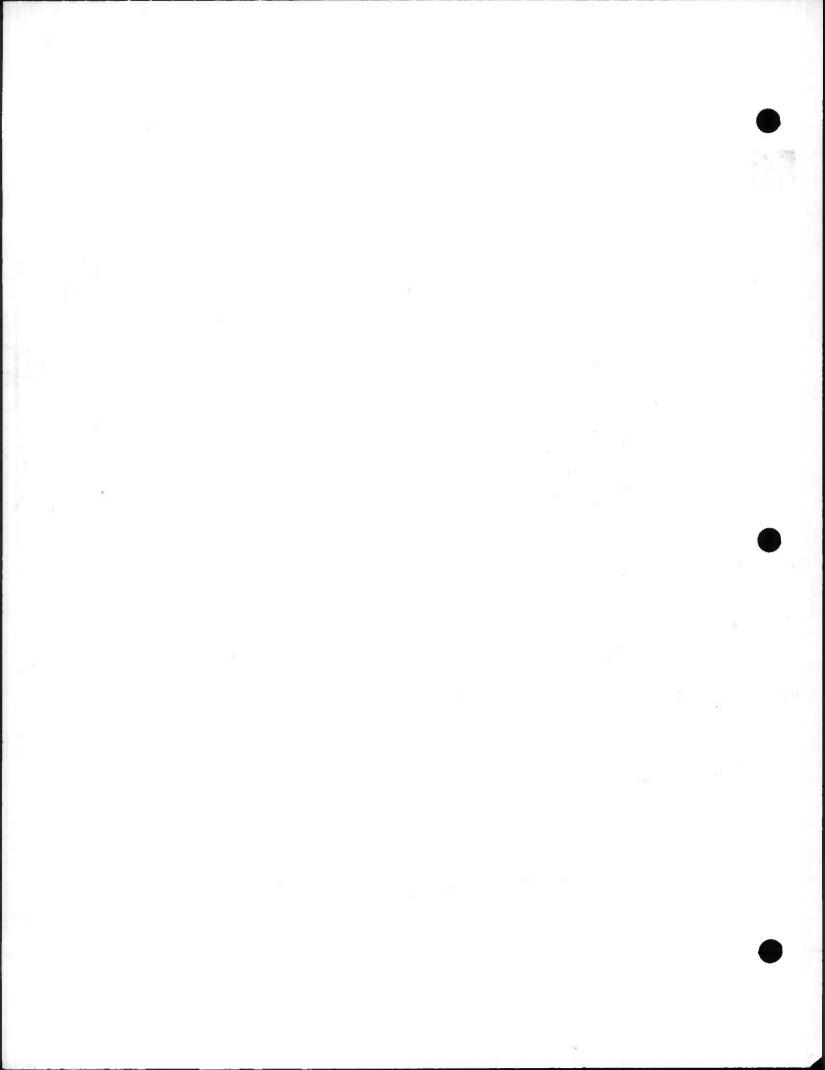
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR		STATE OF I	MARYLA	ND / DEPA	RTMEN	T OF H	IEALTH AND DEATH	MENT	AL HYGIEN	E			
1. DECEDENT'S NAME (First,		nie Mau	de Mo						TE OF DEATH	AY,	YEAR	3. TIME OF DEATH	
4. SOCIAL SECURITY NUMBER		5. SEX		yrs. last birthday)	EIMPE	R t YEAR	IF UNDER 24 HRS.		bruary	1, 1		7:00 A M	
450-05-066		1 🗌 M 2 🔯 F	95		MONTHS	DAYS	HOURS MIN.	(Mo	onth, Day, Year)	1000	Count		
9a. FACILITY NAME (# not in	stitution, give stre	et end number)			9b. CIT	r, TOWN (OR LOCATION OF D		OV. 11,.		NTY OF D	exas	
3719 Gaway	yne Ter	race			1		Spring			Montgomery			
RESIDENCE OF DEC	EDENT 10b. COUNTY											4	
Maryland		gomery		10c. Cl	TY, TOWN							10d. INSIDE CITY LIMITS?	
10e. STREET AND NUMBER	MOIIC	gomery			511		Spring					1 TYES 2 T NO	
3719 Gaway	vne Ter	race				1 "	20906					WHAT COUNTRY?	
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify									SIN? (Specify Yes	United States by Yes or No- 14. RACE - American in			
1 Never Merried 2 Merried FORCES? 1 YES 2 NO If yes, specify Cub								en, Puert		0.110	Speci	k, White, etc.	
3 Widowed 4 Divorced								·y.			Spec	White	
15. DECI (Specify only	EDENT'S EDUCA highest grade co	TION impleted)		16a. DECEDENT'S (Give kind of	work done	during mo	ON sl of working	11	66. KIND OF BUS	SINESS/INC	USTRY		
Elementary/Secondary (0	-t2)	College (t-4 or 5	+)	life. Do NOT L					Telep	hono	Com	nanu	
17. FATHER'S NAME (First, Mi	iddle (eet)			Accoun	tant						COM	parry	
John Clay		a1d					18. MOTHER'S NA			Sumeme)			
190. INFORMANT'S NAME (7)		414	_	195 MAIL IN	G ANNRES	S /Street e	Jennie			n Ctata 7/a	0-4-1		
Jo McDonal		ole					Terrace,				,	20006	
200. METHOD OF DISPOSITI			20b, P							CATION -			
1 ⊠ Buriel 2 ☐ Cremetio 4 ☐ Donation 5 ☐ Other		al from State	- Ga	tery, cremetory or the of H	eave	n Ce	metery	15 -	cil			ng, MD	
21. SIGNATURE OF FUNERAL	L SERVICE LICE	ISEE	1 2 2	00 0= 11	22	NAME AR	IN ADDRESS OF EA	CILITY					
Roch	17	sund		M00198		Rock	west Mon ville. M	larv	nery Av land 20	enue 850-1	2805	Rockville!	
23. PART I. Enter the an shock, or he	seases, or con eart failure. Lis	mplications tha at only one ceu	t ceused i	the death. Do	not enter	the mo	de of dying, suc	ch as ca	rdlec or respi	ratory arr	est,	Approximate interval Between	
IMMEDIATE CAUSE (Fin	ai											Onset and Death	
resulting in death)	→			cardia1		arct	ion						
				CONSEQUENCE C			- 1						
Sequentially list conditi				lerotic		art .	Disease						
If any, leading to immed cause. Enter UNDERLY	NG		(011 110 11 0	ONDEDUCINOE O	, ,.								
CAUSE (Disease or injust that initiated events	ry C.	DUE TO	(OR AS A C	ONSEQUENCE O	F):	_							
resulting in death) LAST	T d.												
PART II. Other significes	nt conditions	contribution to	death had	t and annually	In the con	4 -1.1							
		rterios			in the ur	ideriying	g cause given in	Part I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO	
		II CCI IOS	CIGIO	7515					1 TYES 2	₩ NO	9.1	OF DEATH?	
DID TORACCO III	CE CONTRI	DUTE TO CA	LICE OF	DEATH V	FC []	VIO E	1 11 10-10-1					1 TYES 2 X NO	
DID TOBACCO US 25. WAS CASE REFERRED TO		BUIE IU CA		PLACE OF DEA			UNCERTAI	NЦ					
EXAMINER?	F	IOSPITAL:			OTHE	9.	. X	V	20.00 38				
27. MANNER OF DEATH	1.	28e. DATE OF		28b. Tik		28c. INJ	5 X Residence	_	ter (Specify) EŞCRIBE HOW II	WHIRN OCC	HIBED		
	Pending	(Month, D	sy. Yeer)		JURY M	WO	RK7		24011121101111		7011.25		
3 Suitable	nvestigation Could not be	28e. PLACE O	F INJURY -	- At home, farm,	street, teci		*****	281. LO	CATION (Street e	nd Number	or Rural R	loute Number.	
	letermined	building,	atc. (Specify	")				Git	y or Town, Stete)				
29e. CERTIFIER (Check only 1 X CERTI	FYING PHYSICIA	N: To the best of	my knowled	ige, death occurr	red at the t	lme, date	end place, end due	to the c	ause(e) and men	ner en etet	id.		
one) 2 MEDIC	CAL EXAMINER:	On the beele of e	amination e	and/or investigation	on, in my o	pinion, d	eath occured at the	time, de	te end place, en	d due to th	e ceuse(e) end manner ee stated.	
29b. SIGNATURE AND TITLE		A 1 -	PI	\			29c. LICENSE NUI					(Month, Day, Year)	
	No.	valor i	1 5	Sucy			DOOG	15	>	12	-1-	95	
30. NAME AND ADDRESS OF								-			1		
Donald L.		.D. 80	9 Vei	rs Mill	L Roa	d, F	Rockville	e, M	ary1and	20	851		
FEB 03 199		REGISTRA	R'S SIGNAT	URE U									





BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

0

2 Accident

3 Suicide

1	Amended # 18 1 - REGISTRAR	199 TATE OF MARYLAN	2/2/ND / DEPAI	GCATE	MRT OF HEALTH AND M	ENTAL HYGIEN	one E	95	01:763 Ety.	
	1. DECEDENT'S NAME (First, Middle, Last) Rose Mar	garet Mil	0.5			2. DATE OF DEATH DA	W 1	YEAR 3.	TIME OF DEATH	
À	4. SOCIAL SECURITY NUMBER 5. SE		yrs. lest birthday)	IF UNDER 1 Y		January 31			2:50 AM	
	577 07 1101	M 2 K) F 84	YRS.		AYS HOURS MIN.	(Month, Day, Year)		Country)	CE (State or Foreign	
	9a. FACILITY NAME (If not Institution, give street an	nd number)		9b. CITY, TO	DWN OR LOCATION OF DEAT			Y OF DEATH	ngton D.C.	
FUNERAL DIRECTOR	Manor Care Silver Sp	pring		Silve	er Spring		Mont	gomer	y	
2 E	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10d	I, INSIDE CITY						
듬	Maryland Montgo	omery	8	ilver	Spring				LIMITS?	
¥	10e. STREET AND NUMBER				101. ZIP CODE		10g. CITIZE		COUNTRY?	
N N	10400 Edgewood Avenu	AAS DECEDENT EVER IN U			20901		USA			
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	ORIGIN? (Specify Yes Puerto Rican, etc.)	Black, Wh	American Indian, hite, atc. hite						
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade comple	N 16	Ba. DECEDENT'S	work done duri	IPATION na most of working	16b. KIND OF BUS	INESS/INDUS	STRY		
E	Elementary/Secondary (0-12) Coll-	lege (1-4 or 5+)	ille. Do NOT u	se retired.)	y most of Horning		0 11			
N N	17. FATHER'S NAME (First, Middle, Lest)		Homemak	er		Own Hom				
	Matthew G. Lepley					th D				
) BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	Elizabeth R. Rei Ri 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, Stete, Zi						
2	Michael Fraq Francis	Miles	10201	Grove	sner Place	#807 Rock	ville.	, MD	20852	
	20a. METHOD OF DISPOSITION 1 X Burlai 2 Cremation 3 Removal fro 4 Donation 5 Other (Specify)	rom Stata cemete	ACE AND DATE ry, cremetory or o	OF DISPOSITIO	N (Nama of		CATION — CH	y or Town,	Stata	
	21. SIGNATURE OF YUNERAL BERVICE LICENSEE	1. Cole		22. NAI Fra 500	me and address of facil ncis J. Col University	lins FUne: Blvd.W.	ral HC Sil.Sr	Ome,	Inc.	
	23. PART i. Enter the diseeses, or compil shock, or heart fallure. List or	lications that coused the	ne deeth. Do	not enter the	mode of dying, such	ee cardiec or respir	ratory arrea	ŧ,	Approximate interval Between	
	IMMEDIATE CAUSE (Finel disease or condition	1.						-	Onset and Death	
	resulting in death)	arcinoma of							Weeks	
NO	Sequentially list conditions,					-				
ATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	ONSEQUENCE O	F):						
CERTIFIC	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE O	F):						
	PART II. Other significant conditions conf	tributing to death but	npt resulting	In the under	nying cause given in Pa	irt i. 24n. WAS AN /	NUTOPSY	24b. WEF	RE AUTOPSY FINDINGS	
2	Atrial fibrillation					PERFORI	MED?	AMA	LABLE PRIOR TO IPLETION OF CAUSE	
N: MEDICAL	Cerebrovascular acc	cident					to fine		DEATH? YES 2 X NO	
ä	DID TOBACCO USE CONTRIBUT	TE TO CAUSE OF	DEATH Y	S NC	UNCERTAIN					

25. WAS CASE REFERRED TO MEDICAL	26. PLAC			
1 VES 2 NO	HOSPITAL: 1 Inpatiant 2 ER/Outpatiant 3	DOA 4 Mu	R: reing Home 5 - Reeldence	8 Other (Specify)
27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED

M 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 8 Could not be detarmined

281. LOCATION (Street and Number or Rural Route Number City or Town, State)

29e, CERT	FIER .	CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(s) and menner as stated.
	only	DEFITITING PRISICIAN: To the best of my knowledge, death occurred at the ilme, data and piece, and due to the cause(s) and menner as stated.
one)	- 2	MEDICAL EXAMINER: On the basis of examination and/or important on the second at the standard or the second at the second

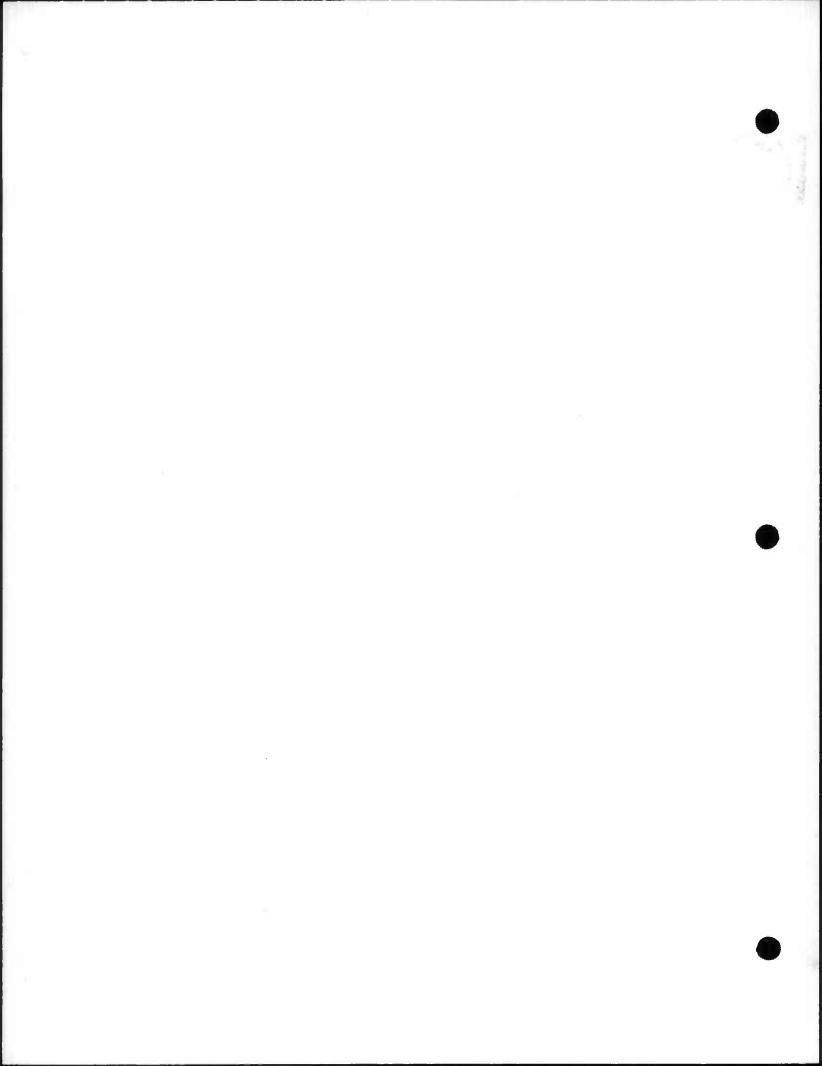
29c. LICENSE NUMBER

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

11251 Lockwood Drive Silver Spring, Md. 20901 Pamela Mulshine, M.D.

31. DATE FILED (Month, Day, Year)
FEB 02 1995 32. REGISTRAR'S SIGNATURE





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IAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled I	le D
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F	this	with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or rem

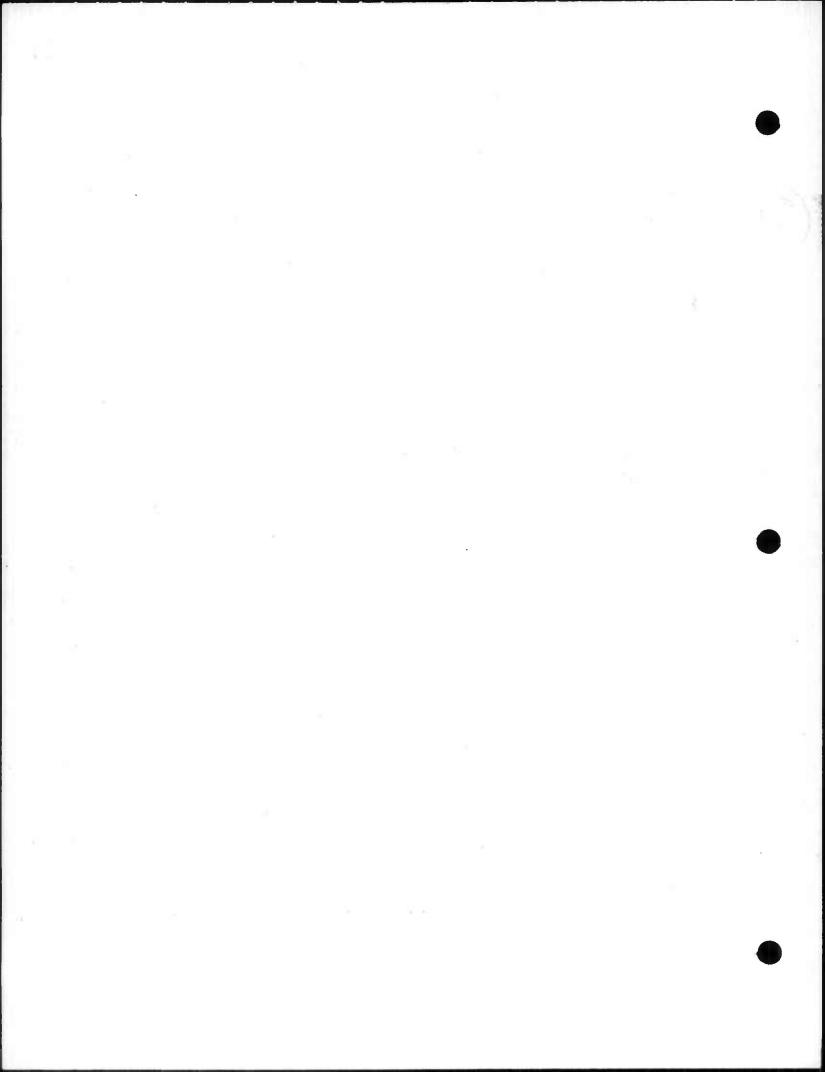
Hellman

Stephen M. Hell 31. DATE JAN 27 1995

6240 Montrose Road

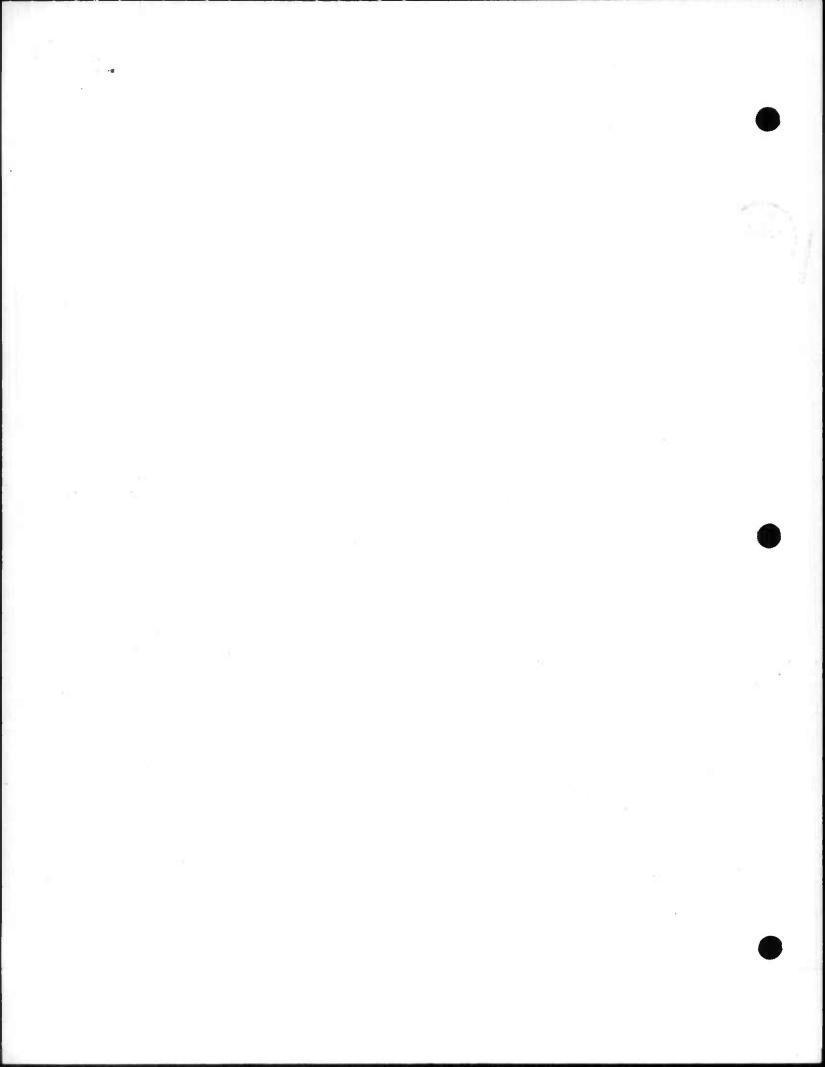
Rockville, Maryland 20852

1	mended #1		TARYLAND /	DEPAR	TMENT C	OF D	ALTH AND A DEATH		REG. NO	E g	om	ry
	1. DECEDENT'S NAME (First, Middle, Lest) Patricia	Elaine			McKi	2021	,	MONTH	OF DEATH		YEAR	. TIME OF DEAT
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthdo			McKirgan Ny			January 24, 1995				5:30
	577-46-5018	1 M 2 X F				B DAYS HOURS MIN.			Day, Year)	6. BIRTHPLACE (State Country)		New Yor
	9e. FACILITY NAME (If not institution, give	street and number)			9b. CITY, TOWN OR LOCATION OF DEATH					9c. COUNTY OF DEATH		
OR	24 Courthouse Squ	are			Ro	ckv	ille		gome	ry		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	гү		10c. CITY	0c, CITY, TOWN OR LOCATION					T	A BIGINE OUT	
E C	Maryland Mo	ntgomery			kvill					1.0	Od. INSIDE CITY LIMITS? X YES 2 1	
	10s. STREET AND NUMBER					IP CODE			10g. CITI			
EB	24 Courthouse Sq		100. ZIP CODE 20850 109. CITIZEN OF WHAT USA									
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1	YES 2 VA	MED	If ye	WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — 14. RACE — America If yes, specify Cuban, Maxican, Puerto Rican, etc.)			- American India White, etc.			
B	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE W	AR OR DATES		1 🗆					White		
8	15. DECEDENT'S EDI (Specify only highest grad		CEDENT'S	T'S USUAL OCCUPATION of work dross during most of working					USTRY			
9	Elementery/Secondary (0-12)	College (1-4 or 5 +	Do NOT use	l of work done during most of working)T use retired.)								
COMPLET		2	ne	Homemaker Own Home								
	17. FATHER'S NAME (First, Middle, Last) Thomas Adrian Cla	ry II				1	E+L 1 T			Sumame)		
	190. INFORMANT'S NAME (Type/Print)	Iy II	1 194	MAILING	Ethel Ballinger NG ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
TO BE	John Brian McKirg	an			Carmody Drive Wheaton Maryland 20902-3624					2-3624		
	20a. METHOD OF DISPOSITION 1 Place AND DATE OF DISPOSITION DATE 20c. LOCATION — City or Town, State Camping Camp											
	4 1 Donation 6 Other (Specify)		Columl	natory or oth	arden	s Ce	emeteryl	128/9	5 Ar1	ingto	on V	irginia
	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE		22. NAN	ME AND	ADDRESS OF FAC	ILITY					
	Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sol. Spr. MD 2090											
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.										ast,	Approxima
	IMMEDIATE CAUSE (Final	clat only one cao								Onset and		
	disease or condition resulting in death)				Failure							1 Year
		DUE TO (UENCE OF):								
TIFICATION	Sequentially list conditions,	b. OUE TO (OR AS A CONSEC	UENCE OF	ENCE OF):					-		
CAT	if any, leading to immediata cause. Enter UNDERLYING		-20,420,100,000	001100/01	E OF):							
Ē	CAUSE (Disease or Injury that Initiated events	OUE TO (OR AS A CONSEQ	UENCE OF	CE OF):					1-		
E	resulting in death) LAST	d										
	PART II. Other algnificant condition	na contributing to	death but not re	sulting in	the under	lying c	ause given in F	Part I.	24a. WAS AN		24b. W	ERE AUTOPSY FIN
5									PERFOR		0	MILABLE PRIOR TOMPLETION OF CA
										A		F DEATH?
MED	DID TOBACCO USE CONT	RIBUTE TO CAL					UNCERTAIN					
IN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL	HOSPITAL:	26. PLAC		OTHER:	one)						
ICIAN: MED	EXAMINER?	1 YES 2 NO HOSPITAL: 1 Input lant 2 ER/Outpetlant 3 DO										
IYSICIAN: MED	EXAMINER? 1 YES 2 NO	-	1 Inpetiant 2 ER/Outpetiant 3 DOA 4 Nursing Home 5					28d. DE\$C	RIBE HOW IN	JURY OCC	CURED	
PHYSICIAN:	EXAMINER?	28a, DATE OF I	NJURY y, Year)	INJU		M 1 YES 2 NO						
BY PHYSICIAN:	EXAMINER? 1 YES 2 X NO 27. MANNER OF DEATH 1 X Natural 5 Pending 2 Accident Investigation	28a. DATE OF I	y, Year)		M 1			281 LOCA	FION (Street o	nd Number	or Burnt Dou	to Mumbas
ED BY PHYSICIAN:	EXAMINER? 1	28a. DATE OF I (Month, Da	INJURY y, Year) INJURY — At her itc. (Specify)		M 1			281. LOCA City of	FION (Street a Town, State)	nd Number	or Rural Rou	te Number,
ED BY PHYSICIAN:	EXAMMER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be datermined	28a. DATE OF I (Month, Day 28e. PLACE OF building, a	y, Year) INJURY — At her	ne, farm, at	M 1	office		City or	Town, State)			te Number,
ED BY PHYSICIAN:	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be datermined 29a. CERTIFIER (Check only 1 N CERTIFYING PHYS	28s. DATE OF I (Month, Ds) 28s. PLACE OF building, a	y, Year) INJURY — At her atc. (Specify) my knowledge, dea	ne, farm, at	M 1 reet, factory,	office	d place, and due to	City or	o(a) end men	ner aa atate	ed.	
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/	7 mended #/ 1. FOR STATE REGISTRAR	7 1/3	1/95	M	RT	N	700	19	OMER	1	95	04765	
	FOR STATE REGISTRAR	STATE OF M	ARYLAND /	DEPAR	TMENT	OF HE	EALTH A	AND I	MENTAL HYGI	ENE	00(7	+	
	1. DECEDENT'S NAME (First, Middle, Last)			-NIII	ICAIL	OF I	DEAI	П.	REG.	NO.		3. TIME OF DEATH	
	Annetta	McGuir	·e					i	January	DAY	/995	9:00 AM	
	4. SOCIAL SECURITY NUMBER 5.		6. AGE (In yrs. les	t birthday)	IF UNDER 1		IF UNDER 2		7. DATE OF BIRTH (Month, Day, Year		B. BIRT	HPLACE (State or Foreign	
	1 J/9-0/-0090 I	□ M 2 □ F	81	YRS.	YRS. MONTHS DAYS HOURS MIN. AUGU								
~	9a. FACILITY NAME (If not institution, give street	and number)			9b. CITY,	TOWN OR	LOCATIO	N OF DE	ATH	9c. Ci	OUNTY OF I		
5	2340 Sun Valley Ci	rcle			W	heat	on			Мо	ntgom	nerv	
DIRECTOR	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR	R LOCATIO	ON					10d. INSIDE CITY	
		ntgomer	У	Wh	eaton	t						LIMITS?	
10e. STREET AND NUMBER 2340 Sun Valley Circle 20906 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 No If yes, specify Cuban, Marican, Puerto Rican, etc.) 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No Israel Rean, etc.)										WHAT COUNTRY?			
	11. MARITAL STATUS 12 1 Never Married 2 K Married	FORCES? 1	YES 2 N		11	yes, spec	ify Cuban,	Maxicar	, Puarto Rican, etc.	Yes or No-	- 14. RAC Blac	CE — American Indian, ck, White, stc.	
В	3 Widowed 4 Divorced	IF YES, GIVE WA	AR OR DATES		11	YE\$ 2	NO 🖺	Specify			Spec	offy: nite	
ED	15. DECEDENT'S EDUCATI (Specify only highest grade con	iON	16a. DE	CEDENT'S	USUAL OCC	CUPATION	d and consisted as a		16b. KIND OF	BUSINESS/		1166	
E		College (1-4 or 5+)	life	Do NOT us	se retired.)	any most	or working						
COMPLETED	8		Hom	emak	er				Own 1				
	17. FATHER'S NAME (First, Middle, Leat)	. 1 . 1	Melino						ME (First, Middle, Mai		•		
BE	Michael M	felind			ADDRESS	(Street and			Mary La				
임	Martin Duane McGuir	٠.							e Wheat			1 00006	
	20a. METHOD OF DISPOSITION		20b. PLACE A	NODATE	OF DISPOSIT				DATE 20c.				
	1 🔀 Burial 2 🗆 Cremation 3 🗆 Removed 4 🗆 Donation 5 🗀 Other (Specify)	from State	Gate	of H	ther place)	Cem	eter	v 1	/81/95Si	lver	Snrin	g.Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LICENS	BEE			22. N	AME AND	ADDRESS	OF FAC	HLITY				
	Gristonler	made	Phina						lins Fund			Inc. .MD 20901	
	23. PART i. Enter the diseases, or com ahock, or heart failure. List	plications that	caused the de	nth. Do r	not enter t	he mode	e of dyin	g, such	ea cerdiac or re	apiratory	arreat,	Approximata	
	IMMEDIATE CAUSE (Final	, only one caus	e on eech line.									Interval Batween Onset and Death	
	disease or condition	Ca	deac	A	ne	57						1 hour	
		DUE TO (OR AS A CONSEC		F):	-	, ,		Fai	-1			
<u>S</u>	Sequentially list conditions, b	DUE TO (DR AS A CONSEO	424	live	- /	1-00	V	pai	ane	*	/year	
RTIFICATION	if any, leading to immediate cause. Enter UNDERLYING		on AS A CONSEC	YENCE O	<i>P</i>							/	
Ĭ	CAUSE (Disease or Injury that initiated eventa	DUE TO (OR AS A CONSEO	UENCE O	F):								
	resulting in deeth) LAST												
LCE	PART II. Other aignificant conditions of	ontributing to c	feath but not re	auiting	in the und	erivina	cause giv	ven in l	Part I. 24e WAS	AN AUTOPS	y 241	b. WERE AUTOPSY FINDINGS	
CA	Severe C	coron	au an	Lou	d	12	ear	a	PER	FORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
			1		1					2 NO		OF DEATH? 1 ☐ YES 2 NO	
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIB	UTE TO CAL	JSE OF DEAT	TH YE	S 🗆 N	0 🗆	UNCE	RTAIN	17/			7 7 7 7 7 7 7	
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	26. PLACE	E OF DEAT	OTHER:								
IXS!	1 YES 2 NO 1	☐ Inpatient 2 ☐			4 D Nursir	ng Home		dence (Other (Specify)				
	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day		26b. TIM INJ	E OF 2	8c. INJUR	K?		28d. DESCRIBE HO	W INJURY C	CCURED		
B	Accident investigation 3 Suicide & Could set be	26a, PLACE OF	INJURY — At hor	ne farm (treet lector	1 YE	S 2 🗌	NO	284 LOCATION (Sta	int and Mont	has as Bumil	Davida Musebas	
3 Sulcide 6 Could not be detarmined 26a. PLACE OF INJURY — At home, farm, streat, factory, office building, etc. (Specify) 26b. PLACE OF INJURY — At home, farm, streat, factory, office City or Town, State) 26f. LOCATION (Street and Number or Bural Route Number, City or Town, State)									House Number,				
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSICIAN	N: To the best of a	ny knowledge des	th occurr	od at the time	a deta a	nd plece a	and due 1	to the equate) and	manner er	talad		
MC	(Check only one) 2 MEDICAL EXAMINER: 0											a) and manner as stated.	
	286. BIGNATURE AND TITLE OF CERTIFIER	/	10				29c. LICEN					O (Month, Day, Year)	
BE	Moderat L.	21	140					-	00	> /	1	28 /995	
2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE	OF DEATH (ITEM	27) (Type,	Print)					14	mues	7-0,1113	
- 1	Robert L.	- 1-0	1527	- <	-1	1 6			00	0	4.	:YL MA	



TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

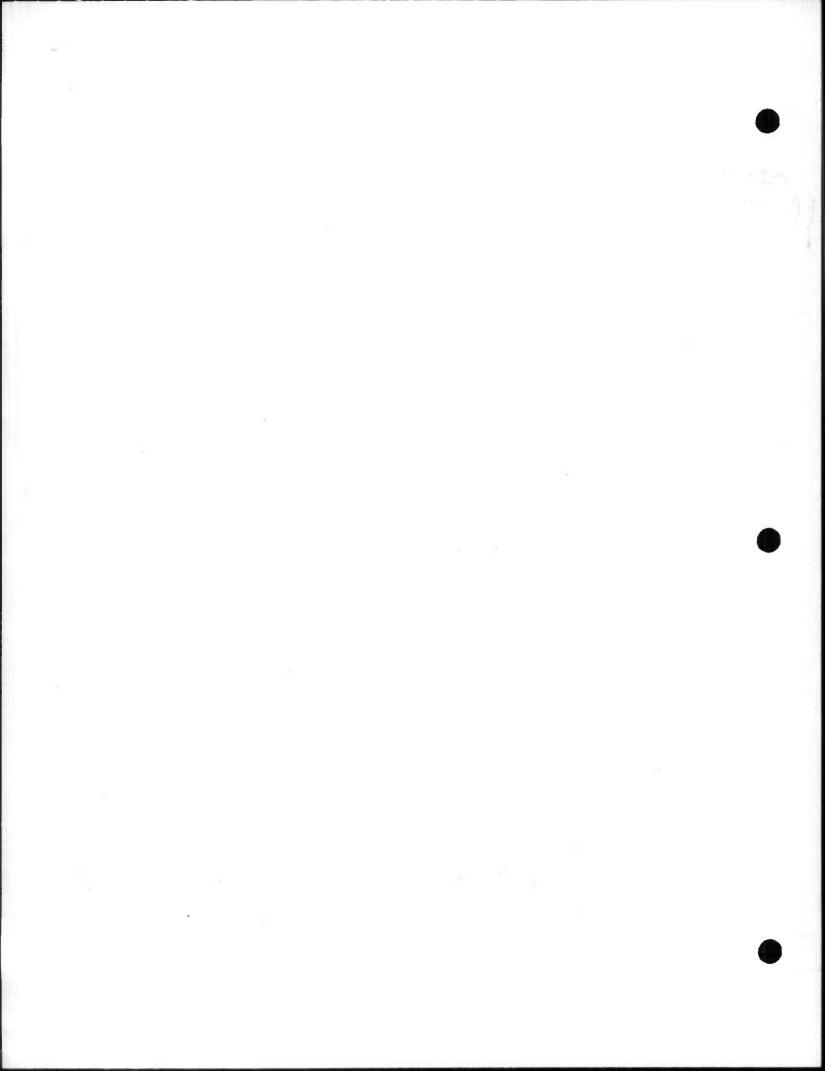
31. DATE FILEO (Month, Day,

JAN 30 1995

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE REGISTRAR		STATE OF N	MARYLA	AND / CEI	PEPARTI	MENT O	F HE	ALTH ANI	MEN	TAL HYGIE REG. N	NE J		-	
1. DECEDENT'S NAME (First,	Middle, Last)									ATE OF DEATH			3. TIME OF DEATH	
Anna		Ceceli	a			Mill	er		Ja	onth Inuary	28 1	995	4:30 A	
4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (II	n yrs. lest b		F UNDER 1 YE		IF UNDER 24 HRS	. 7. D	ATE OF BIRTH Month, Day, Year)	1913	8. BIRT	HPL OO Seambrie	
577-58-599		1 🗆 M 2 💢 F		81	YRS.	ONTHS DA	IVS I	HOURS MIN		bruary	27		trict of	
9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9	b. CITY, TO	WN OR	LOCATION OF			7	INTY OF C		
15033 West		Court				Sil	ver	Sprin	g		Mo	ntgo	mery	
RESIDENCE OF DEC	10b. COUNT	,			40 - 0074	OWN OR L						1	,	
													10d. INSIDE CITY LIMITS?	
Maryland	Mon	gomery			S1	lver			1 - YES 2					
71	1 0							ZIP CODE					WHAT COUNTRY?	
15033 Westh	OIE CO							20906				U.S.,		
1 Never Merried 2	Married	12. WAS DECEDEN FORCES? 1	YES	2 X NO	ED	13. WAS	DECEN s, speci	NDENT OF HIS lify Cuben, Max	PANIC OF Ican, Pue	IIGIN? (Specify Yorto Rican, etc.)	es or No-	14. RAC Blac	E — American Indian, ik, White, etc.	
3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES							NO Spi	iclfy:			Spec	からいけった		
15. DEC	EDENT'S EDU	CATION	Т	16a, DECE	DENT'S US	UAL OCCUI	PATION			16b. KIND OF B	ISINESS/IN	DIJETRY	WALLE	
(Specify only Elementary/Secondary (0	r higheat grade	completed) College (1-4 or 5 -		(Give	kind of wor	done durin	g most	of working		TOU. KIND OF B	USINESS/IN	DUSTRI		
12	-12)	College (1-4 or 5 -	"	- 1	Rookk	eepei	r			U.S. (OWOR	nmani	-	
17. FATHER'S NAME (First, MI	iddle, Lest)				DOORK	ССРС		18. MOTHER'S	NAME (F)	rst, Middle, Meide		mien	L	
Walter	S.	Dodge						Annie		lizabet		John	con	
19a. INFORMANT'S NAME (7)	i/pe/Print)			19b. I	MAILING A	ORESS (Str	reet and			Number, City or To			5011	
Ann E. Cu	rley												inia 22020	
20a. METHOD OF DISPOSITI	ON		20b.	PLACEAN	DDATEGE	OITIPORITIO	N /Namo	e of		DATE 200 L	OCATION	City or To	Parts	
1 Buriel 2 Crematio		oval from State	ceme	elery, creme	tory or other	plece)	cem:	atory	1/20	/05 A	oscan.	dredo	, Virginia	
21. SIGNATURE OF FUNERAL		ENBEE	17 .		0210	22. NAM	E AND	ADORESS OF	FACILITY					
Francis J. Collins Funeral Home, Inc.														
1/100	2 -6	.00	ere	500 University Blvd.W. Sil.Spr.,MD. 20901										
23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrest, Approximate											DIT			
shock, or haart failure. List only one ceuse on each line.										cardiec or res	piratory ar	rest,	Approximate	
immediate cause (Fin	sart failure.	complications that List only one cau	t caused se on ee	the deat	h. Do not	anter the	mode	e of dying, a	uch aa	cardiec or res	piratory ar	rest,		
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32. REGISTRAR'S SIGNATURE



31. DATE FILEO (Month, Day, Year)

02 1995

32. REGISTRAR'S SIGNATURE

1	Amend #	1 #	92	2/2/0		m	7		0	1	95	j	1,761	
	FOR 1 - STATE REGISTRAR		STATE OF I	MARYLAND /	DEPAR	RTMENT	OF H	EALTH A	AND M	ENTAL HYGIEI	VE Z	(0)	ung	
	1. DECEDENT'S NAME (First	Middle, Last)) Kei	neth	717 2010			ald		2. DATE OF DEATN	DAY O	YEAR 3	TIME OF DEATH	
	4. SOCIAL SECURITY NUM	BER	5. SEX 1 🔯 M 2 🗆 F	6. AGE (In yrs. les		IF UNDER 1	VEAR DAYS	IF UNDER 24	MIN.	7. DATE OF BIRTH (Month, Day, Year)	1	Country)	ACE (State or Foreign	
Á	587-56-7219 9a. FACILITY NAME (If not in	natitution, give s	treet and number)	89	YRS.		9b. CITY, TOWN OR LOCATION OF DEATN					1905 New York		
ron	Washington		ist Nurs	ing Home	9			Park				ntgom		
DIMECTOR	100. STATE	10b. COUNT				Y, TOWN OR		ON				10	d. INSIDE CITY	
-	Maryland		ntgomery		Ad	elphi						LIMITS? ☐ YES 2 X NO		
FUNERAL	1733 Metzerott Road 20										USA		AT COUNTRY?	
BY FUN	11. MARITAL STATUS 1 X Never Merried 2 3 Widowed 4 Divo	LEVER IN U.S. AR YES 2 1 AR OR DATES Q 5 2	IMED NO	1 11	yes, spe	NOENT OF	Maxicon,	ORIGIN? (Specify Ye Puerto Ricen, etc.)		14. RACE — Black, V	American Indian, White, atc. White			
ED	1944-1952 1s. DECEDENT'S EDUCATION (Specify only highest grade completed) 1944-1952 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working								16b. KIND OF BU	SINESS/INDU	JSTRY			
COMPLET	Elementary/Secondary (0		College (1-4 or 5 +	Aldra-	Pri	se retired.)	ing mo	or working		Polific	~ f ~			
COM	17. FATHER'S NAME (First, M							18. MOTHE	R'S NAME	Relia (First, Middle, Maiden				
BE	Felix McDona									h Dwyer				
6	19e. INFORMANT'S NAME (Type/Print) Father Robert Shay 1733 Metzerott Road Ade 20e. METHOD OF DISPOSITION 1 Description State Commission State													
										DATE 20c. LC	CATION — C	ity or Town,	State	
H	4 Donation 5 Other 21. SIGNATURE OF FUNERIA		ENSEE /	Ноту	Irin:	22. N	emet	ery	2/2 OF FACIL	/95 For 500 Uni	t Mit	chell	Alabama	
	> 4x	9 K	ell			0	011.	~5	E	Silver	Sp-in	g, MI	20901	
1 0		eart failure.	complications that List only one cau	caused tha da se on aach iina	ath. Do r	not antar ti	ha mod	e of dying	g, such a	aa cardiac or resp	iratory arre	st,	Approximata Interval Between	
	iMMEDIATE CAUSE (Findisease or condition resulting in death)	iai -	Myo	cand	liat	0 h	La	ny	ko	zv.			Onset and Death	
			ODE TO	(OR AS A CONSEC	DUENCE OF		1							
CERTIFICATION	Sequantially list conditi		OUE TO	OR AS A CONSEC	DUENCE OF	F):								
FICA	cause. Entar UNDERLYI CAUSE (Disease or Inju that initiated events		DUE TO	OR AS A CONSEC	NIENCE O	F).								
ERTI	resulting in death) LAS	T (1		, o									
	PART II. Other significa	nt condition	contributing to	daath but not r	asuiting i	n the unde	ariying	cause giv	en in Pa			24b. WE	RE AUTOPSY FINDINGS	
PHYSICIAN: MEDICAL					<u>.</u>					PERFOR		CO	AILABLE PRIOR TO MPLETION DF CAUSE DEATH?	
N.												1[YES 2 NO	
CIA	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:			OTHER:	26. PLA	CE OF DEAT	TH (Check	only one)				
HYS	1 YES 2 NO		1 inpatient 2	NJURY	28b, TIM	4 Nursin	g Nome Sc. INJUI			Other (Specify)	N.IIIBA OCCI	IDED		
ВУ Р		Pending nvestigation	(Month, De			M M	WORI		A 1			HED		
		Could not be letermined	28e. PLACE Of building,	INJURY — Al horate. (Specify)	me, ferm, s	treet, fectory	y, office		21	61. LOCATION (Street of City or Town, State)	and Number o	r Rural Route	Number,	
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTI	IFYING PHYSIC	CIAN: To the best of s	my knowledge, dec	nth occurre	nd at the lime	e, date a	nd place, er	nd due to	The cause(s) and mar	nner as stated	d, cause(s) en	d manner as stated.	
BE C	29b. SIGNATURE AND TITLE			A 4	D			29c. LICENS	E NUMBE	iR .			enth. Day, Year)	
2	30. NAME AND ADDRESS OF	PERSON WHO			27) (Type.	Print)	0	02	428	57	-/-	29.9	76	
- 1	14 11/51	1+ 19	7 245	2 103%	011	120	11	100	5 1	1-1111	21 1	111	0 100 1	



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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and compietely filled in by the funeral director, page 5 should be detached for use as the burial-trope filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. hours after death. Page 6 may be retained by the hospital or attending physici TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

1	•	FOR STATE REGIS		ΑI	R
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4	7.	ohn	٨	1	-

	1 - STATE REGISTRAR	CERTIF	ICATE (OF D	EAT	ANU N H	REG. NO.	t				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH 1995 3. TIME OF DEATH					
	John Albert Nicholson						January 9, 199			0034 Am M		
		s. last birthday)				HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHI	PLACE (State or Foreign		
		53 YRS.	MONTHS DA	TYS HI	OURS	MIN.	Dec.14,19	31	Mary			
~	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TO	WN OR L	OCATIO	N OF DE	ATH	9c. COL	JNTY OF DE	ATH		
5	Kent & Queen Anne's Co. Hospita	al Inc.	Che	este	town	n		1	Kent			
E	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	10c. CIT	Y, TOWN OR L	OCATION						10d, INSIDE CITY		
E	Maryland Kent	S.	ill Po	ond						LIMITS? 1 X YES 2 NO		
7	100. STREET AND NUMBER	1 2	TIT L		P CODE	_	10g. CITIZEN OF WI			21		
EB	12805 Rosedale Cannery Rd.				216	67	USA					
FUNERAL DIRECTOR	11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S		13. WAS	DECENE	DENT OF	HISPAN	C ORIGIN? (Specify Yea	ecify Yea or No. 14, RACE — American Indian.				
BY F	1 Never Married 2 Married FORCES? 1 1 FYES 2 3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES			YES 2 1			, Puarto Rican, etc.)	Black, White, etc. Specify:				
	15 Dec. 48-3	June 49							White			
	(Specify only highest grade completed)	Give kind of a life. Do NOT us	work done durin	PATION og most o	f working		16b, KIND OF BUS	SINESS/IN	DUSTRY			
7	Etamentary/Secondary (0-12) College (1-4 or 5+) 12 Ma			mar	ari a	010	Confoo	1				
O 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)												
											BE	10. INFORMANT'S NAME (Top Print)
9	Catherine M. Nicholson 12805 Rosedale Cannery Rd. Still Pond, Md. 21667											
	20s_METHOD OF DISPOSITION 1 \(\) Burlel 2 \(\) Cremetton 3 \(\) Removal from State cemeters	CEANDDATE	OF DISPOSITIO	N (Name o	of		DATE 20c. LO		Cify or Tox			
	4 Donation 5 Other (Specify) St1	11 Pon	d Ceme	tery	y Ja	m.12	2,95 Sti	11 P	ond,	Md.		
	21. SIGNATURE OF TONERAL SERVICE LICENSEE			AE AND A			s Funeral	Home				
	Xhry B Illows						s runeral hestertow			620		
	23. PART I. Enter the disease, or complications that caused the	deeth. Do r	not enter the	mode	of dyin	g, such	as cerdiec or respi	ratory si	rest,	Approximate		
	ahode, or heert feilure. Liet only one ceuee on eech IMMEDIATE CAUSE (Finei disease or condition resulting in deeth) BUE TO (QH AS A CO)	Iline.	Ta	ch	37	es	ndes	w	th	interval Between Onaet and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immadiate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST b. Due to (on as a consequence of): Due to (on as a consequence of): Due to (on as a consequence of): Due to (on as a consequence of): Due to (on as a consequence of):											
	PART II. Other significent conditions contributing to death but n	ot resulting	in the under	ying o	use gi	ven in f	Pert I. 24s. WAS AN			WERE AUTOPSY FINDINGS		
MEDICAL	severe Chaine Lu	7 12	2000	20	6	Kro	1 YES 2	-22		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
ME	Ronal Fasture								- 1	1 TES 2 NO		
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF D	ÉATH YE	S 🗆 NO		UNCE	RTAIN						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	LACE OF DEAT	H (Check only OTHER:	one)								
YSI	1 YES 2 NO 1 Impetient 2 ER/Outpetien		4 - Nursing	Home 5	5 🗆 Resi	idence (Other (Specify)		_			
	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Dey, Yeer)	28b. TIM INJ	URY	WORK?	2		28d. DEŞCRIBE HOW II	NJURY OC	CURED			
2 Accident Investigation M 1 YES 2 NO												
COMPLETED									oute Number,			
	29a. CERTIFIER		Santa Contract						arra k i			
₽ I	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge one) 2 MEDICAL EXAMINER: On the basis of examination and									and manner as stated		
	29b. SIGNATURE AND TITLE OF CERTIFIER											
B	Deergo in Das	-	NN	70 -	C. LICEN	ISE NUMI	A.	29d. DA	SIGNED	Month, Day, Year)		
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CALLE OF DEATH	(TEM 30 /Nod	Print)		25	41)	1	-	1719)		
	DR. GEORGE M. 16	UNG	-	100	3	30	and c	1	1			
415	31. DATE FILED (MOJANY, 10) 95	Ison-Pa	dell				- Tolke		1.1			

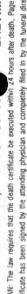
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician.

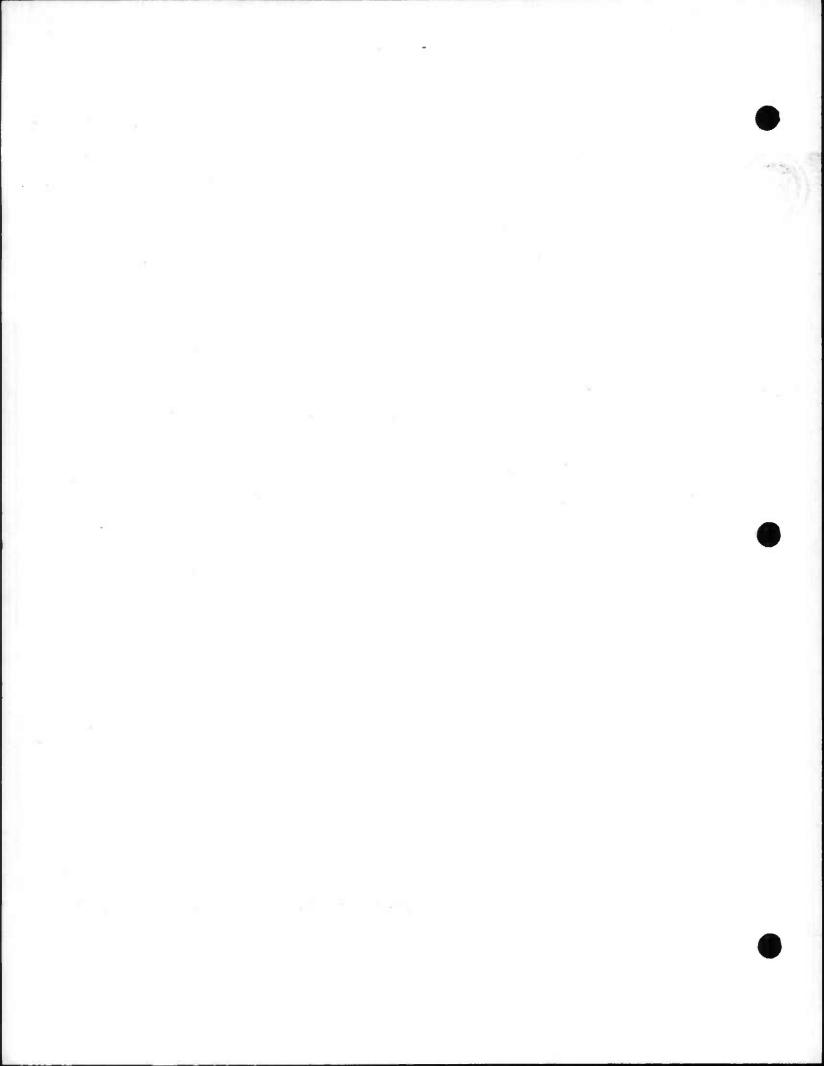
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND M

	1 - STATE REGISTRAR	SIMIE UT MA		ERTIF	ICATE	OF	DEATH	MENIA	AL HYGIEN REG. NO.	Ł			
	1. DECEDENT'S NAME (First, Middle, Last)	·····	CERTIFICATE OF DEATH						2. DATE OF DEATH 3. T			3. TIME OF DEAT	Н
	BENJAMIN	Ε.	NE	LSO	ON			JAI	JANUARY 27			12:45	
	4. SOCIAL SECURITY NUMBER		. AGE (In yrs. les		IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATI	E OF BIRTH		B. BIRTH	PLACE (State or Fo	reign
	218-20-6752	1 XM 2 - F	65	YRS.	MONTHS	DAY8	HOURS MIN.	JAN	. 5, 19	29	Country	YLAND	
	9a. FACILITY NAME (If not institution, give s						R LOCATION OF D	_			JNTY OF DE		
DIRECTOR	RTE.343&LOVERS	S LANE			CAM	ıBRI	DGE			DC	RCHI	ESTER	
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	v		400 017	y, TOWN C								
IRI		CHESTER			.,							10d. INSIDE CITY LIMITS?	
	MAKILAND DUK			AMBR					1 ☐ YES 2 ☒ NO			NO	
FUNERAL	2436 IDIAN BON		101. ZIP CODE					200			USA		
N	11. MARITAL STATUS		NAS DECEDENT EVER IN U.S. ARMED			21613			NIC ORIGIN? (Specify Yes or No-				
BY FL	1 Never Married 2 X Married 3 Widowed 4 Divorced	YES 2 N	S 2 NO If yes, specify Cuben, Mex					cen, Puerto Rican, atc.)			White, atc.	en,	
6	15. DECEDENT'S EDU		16a. DE	CEDENT'S	NT'S USUAL OCCUPATION			16	b. KIND OF BUS	HNESS/IN	DUSTRY		
Ħ.	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Gr	Do NOT us	work done one retired.)	luring mo	st of working						
APL	12th		LL	I.LABORER					COLDW	ATE	R		
COMPLETED	17. FATNER'S NAME (First, Middle, Last)						18. MOTNER'S N	AME (First,	Middle, Meiden	Sumeme)			
BE (WILLIAM NELSON						LOUI	SE I	K UNK	NOW	1		
TO B	19a. INFORMANT'S NAME (Type/Print)		19b	. MAILING	ADDRESS	(Street e	nd Number or Rural	l Route Nur	nber, City or Town	er, City or Town, State, Zip Code)			
-	DOROTHY MAE NEL	SON		243	6 IN	DIAN	BONE R	OAD,	CAMBRI	DGE,	MD.	21613	
	20e. METNOD OF DISPOSITION 1) Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	20b. PLACE A								c. LOCATION — City or Town, State		
		Maria Carlos Car	ARI	ES C				EB.	1,95	CAMI	BRIDG:	E, MD.	
	22. NAME AND ADDRESS OF FACILITY BENNIE SMITH FUNERAL SERVICES												
	1						. BOX 1					601	
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death												
2	PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS												
EDICAL	PERFORMEO?								MEO?		AMAILABLE PRIOR 1 COMPLETION OF C OF DEATH?	го	
PHYSICIAN: MEI	DID TOBACCO USE CONTI	DIRLITE TO CALL	SE OF DEAT	ru vr	s 🗆 .	10 [LINICEDTAL	A				1 X YES 2	10
AN	25. WAS CASE REFERRED TO MEDICAL	KIDOIL 10 CAU				_	UNCERTAI						
SIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 TO YES 2 NO 26. PLACE OF DEATN (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA								DO 7	DETDE	CTT/		
¥	27. MANNER OF DEATN	28e. DATE OF IN	JURY	28b. TIME OF 28c. INJURY AT					SCRIBE NOW IN			NOTHE	210
ВУР	1 Natural 5 Pending	(Month, Day,	rear)	INJ	URY	WO	RK? ES 2 NO						
0 8	2 Accident Investigation 3 Suicide 8 Could not be	NJURY — At hor	ne, farm, s	treat, facto			281. LOCATION (Street and Number or Rural Route Number,						
	4 Nomicide determined building, etc. (Specify)									•			
COMPLETE	29e. CERTIFIER (Check only One) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(e) end menner es stated.												
BE	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, L												
10 B	Warreld Sty U	1D				O.C.M	I.E.		JA	N. 28	1,1995		
ř	DONALD G WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201												
	31. DATE FILED (Month, Day, Year)	32 AEGISTRAR'S	SIGNATURE	latt								-	
- 1	JAN 31 1995	Have we	magn swall	A CONTRACTOR									



IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



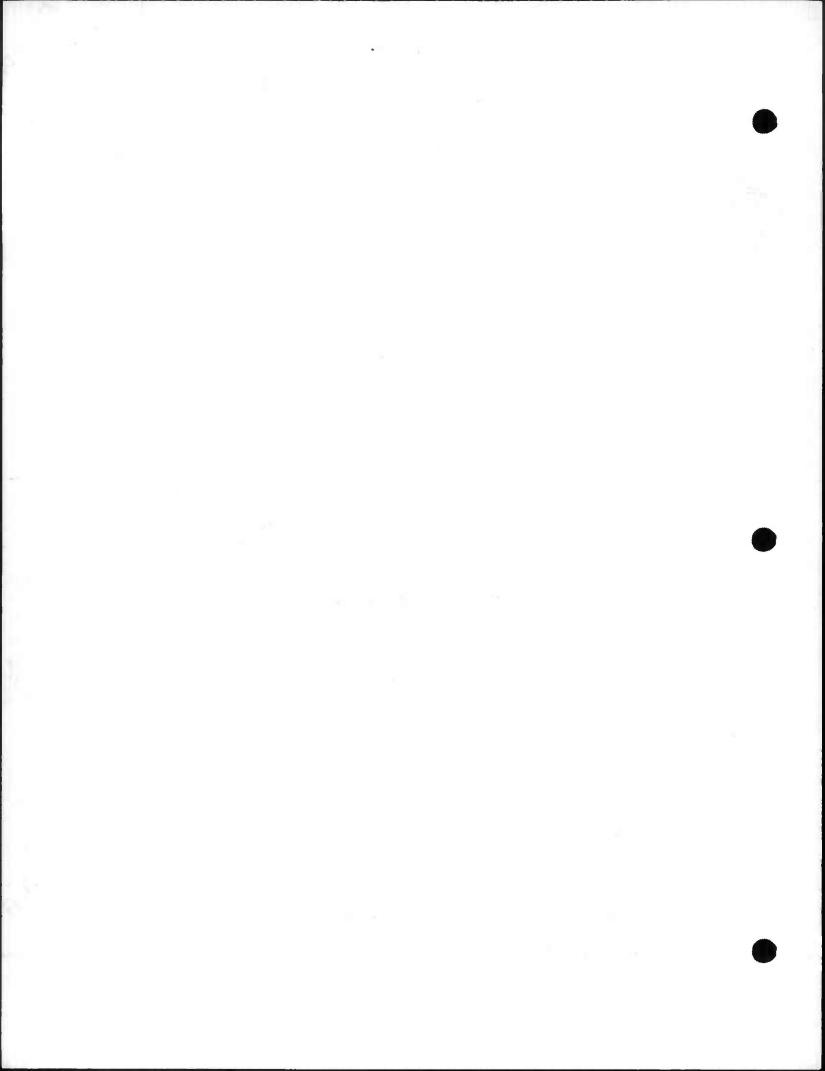
L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with fours after death. Page 6 may be retained by the hospital or attending physician.
DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit perm hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with fours after death. Page 6 may be retained by the hosp TO THE FLINERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

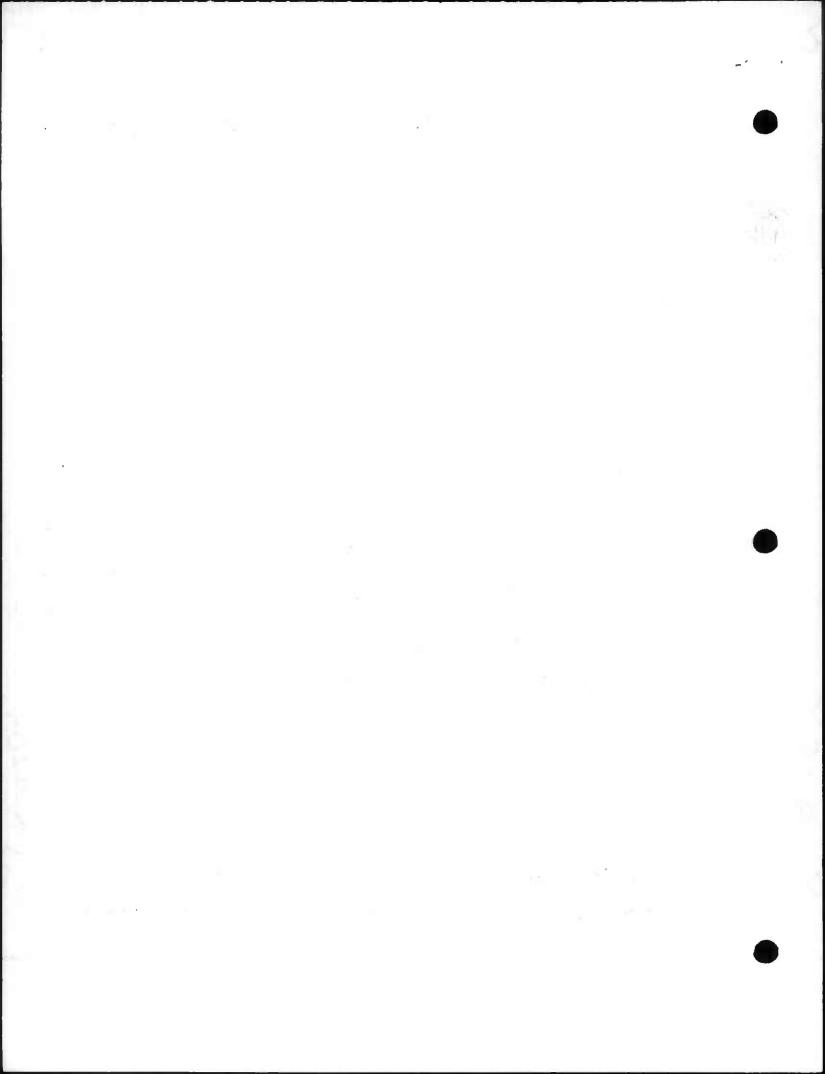
	1 - STATE REGISTRAR		CERTIFIC	ATE OF	DEATH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH DA	Y YEAR	3. TIME OF OEATH	
	REUBEN	12 N				1 2	3 95		
		6. SEX 6. AGE (UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Cour		
	2 1 7 - 0 9 - 0 8 8 9 1 9e. FACILITY NAME (If not institution, give stree			CITY TOWN C	R LOCATION OF DE	Jan. 14,			
œ	Dorchester Gen			ambrio		AIT	9c. COUNTY OF DEATH Dorchester		
DIRECTOR	RESIDENCE OF DECEDENT	110/03/					voren	ester	
뿔	MD. 106. COUNTY	hestre		OWN OR LOCAT				10d. INSIDE CITY LIMITS?	
	100. STREET AND NUMBER	165226		Hurloc	ZIP CODE			1 YES 2 NO	
FUNERAL	414 Charles Stre	2.01		101	21643	2		WHAT COUNTRY?	
3	11. MARITAL STATUS	2. WAS DECEDENT EVER IF	U.S. ARMED		ENDENT OF HISPAN	IC ORIGIN? (Specify Yes	USA or No.— 14. RAG	E — American Indian,	
BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES			2 XNO Specify	n, Puerto Rican, atc.)		ck, White, etc.	
	15. DECEDENT'S EDUCAT	ION	18s. DECEDENT'S USL	IAL OCCUPATION	NA.	16b. KIND OF BUS		WILLE	
COMPLETED	(Specify only highest grade cor	mpleted) College (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during mo-		IGB. KIND OF BUS	INESS/INDUSTRY		
AP.	7	0	Machini	st		Can.	Manuka		
8	17. FATNER'S NAME (First, Middle, Last)				16. MOTHER'S NAI	ME (First, Middle, Malden			
B	Jasper Neal					Paul			
2	Florence L. Nea	. //				loute Number, City or Town			
Ì	200. METHOD OF DISPOSITION	20b	PLACE AND DATE OF D	ICTLES ISPOSITION (No	STREET	HUTLOC	K.MD.	21643	
	1 Burist 2 Cremation 3 Remova 4 Donation 5 Other (Specify)	from State	antani aramatani as athas	nlanal		1/26/95		,	
	21. SIONATURE OF JUNE ALL SERVICE LICEN	SEE		22. NAME AN	ID ADDRESS OF FAC	CILITY		IC IVIII	
	W And			Fede	xamson ralsbur	Funeral	Home 632		
	23. PART I. Enter the diseases, or con shock, or heert fellure. Lie	aplications that caused	ach line	enter the mo	de of dying, auch	as cerdiac or respir	ratory errest,	Approximate	
	IMMEDIATE CAUSE (Finei	^	Res		ry Failu			Onset and Death	
ļ	disease or condition resulting in deeth) e		IRATO CONSEQUENCE OF:	27	FAILL	IRE		SEV.DAYS	
_			STA-9	= 0	. D.P.	, Δ.		Sev. years	
2	Sequentially list conditione, if any, leeding to immediate	DUE TO (OR AS A	CONSEQUENCE OF):					Dev. years	
2	CAUSE (Disease or Injury C.	End Stage C		Lructi	ve rumio	nary Disea	se		
CERTIFICATION	that initieted events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF):						
핑	d								
S	PART II. Other significent conditions of	ontributing to death b	ut not resulting in ti	he underlying	cause given in	Pert i. 24s, WAS AN PERFOR		b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
ᄀᆘ	SEVERE A	7-161-102	CLENOV	ic inc	2114 1130	TO YES 2	E NO	OF DEATH?	
Σ	DID TOBACCO USE CONTRIB	LITE TO CALISE O	E DEATH VEC		LINICEDTAIN			1 TES 2 NO	
¥	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEATH (UNCERIAIN	ч⊔ј			
PHYSICIAN: MEI		OSPITAL:		THER: Nursing Nome	5 Residence	8 Dther (Specify)			
£	27. MANNER OF DEATN	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJI	JRY AT RK?	28d. DESCRIBE NOW IN	IJURY OCCURED		
⋒	1 Netural 5 Pending Investigation				ES 2 NO				
<u>ا</u> ه	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, term, stree #fy)	t, factory, office	•	28t. LOCATION (Street s. City or Town, Stete)	nd Number or Rural	Route Number,	
	29s. CERTIFIER	N. To the best of a state of							
COMPLET	(Check only one) 2 MEDICAL EXAMINER: (N: To the best of my knowl On the besis of exemination						s) and manner as stated	
ы Ш	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM			D (Month, Day, Year)	
m	1029	2		- 1	λ	76 t	► //:	-3/6/	
۹ ا	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Prin	t)	-				
	Mahood Shariff		Aurora Str	eet	Cambi	ridge, MD	21613		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	ATURE					_	
	FEB 3 1995	Julia diavidea	W. A. CHARLES					DHMH-16 Rev 1/89	
								PALLES LO LIGA 1/08	



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	ä	1		
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within exploras after death. Page 6 may be retained by the hospital or attending physicial	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-training			
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AN: I	ifficate	State	r lter	
WSICI	is cert	ith th	ed, o	
NG P	fter th	eath w	mark	
TEND	DR: A	o July	50	
DR AT	DIRECT	OUIS a	lem 2	
PITAL	RAL	be fied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
HOS	FUNE	within	TAN	
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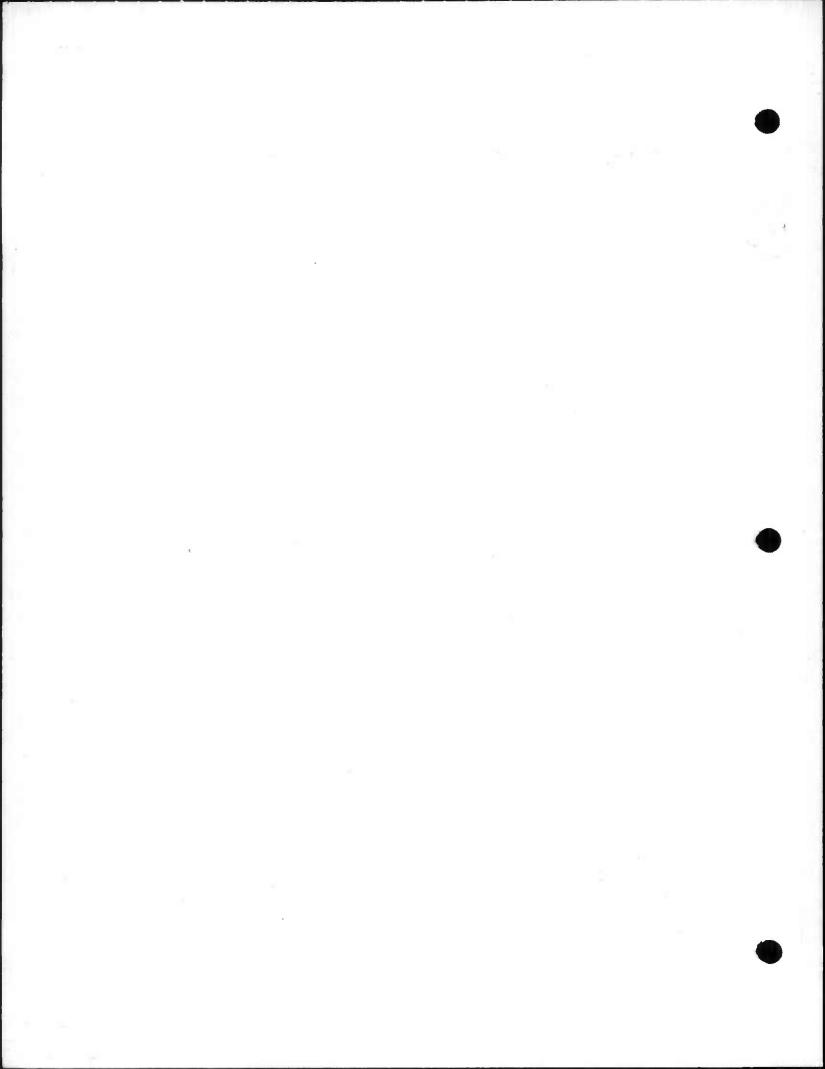
	FOR STATE REGISTRAR		STATE OF I	MARYLAND /		RTMENT				MEN'		YGIEN EG. NO.				
	1. DECEDENT'S NAME (FIRST,		f.	NOL	0					2. D	ATE OF C	DEATH D	NY .	QYEAR.		E OF DEATH
- Section 1	4. SOCIAL SECURITY NUMBER 074-03-499	99	5. SEX	8. AGE (In yrs. les 90	t birthday) YRS.	IF UNDER	DAYS	IF UNDE	MIN.	12	ATE OF B North, Day 2 / 1	(Year)	04	NEV	y Y((State or Foreign
TOR	CARROLL CO	OUNTY		OSPITAI	Ĺ.	96. CITY, TOWN OR LOCATION OF DE WESTMINSTER				eath 9c. county of CARRO						
DIRECTOR	10a, STATE MARYLAND	10b. COUNTY	CARRO	LL		ESTA									LII	SIDE CITY MITS?
FUNERAL	100. STREET AND NUMBER 824 WINCHI	ESTER	DR.				101	. ZIP COD	21	157	7			USA.	VHAT CO	
ВУ	11, MARITAL STATUS 1 Never Married 2 SWidowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2 X		If yea, specify Cuban, Maxican, Puarto Rican, atc.) Bia					14, RACE Black Speci	k, Whita,	rican Indian, atc. HITE			
COMPLETED	15. DEC (Specify only Elementary/Secondary (0	EDENT'S EDU y highest grade 0-12)	CATION completed) College (1-4 or 5	(G life.	ive kind of . Do NOT u	DENT'S USUAL OCCUPATION kind of work done during most of working o NOT use retired.) EST ENGINEER							CTU	DUSTRY RINC	3	
BE CON	17. FATNER'S NAME (First, Middle, Last) VALENTINE NOLD 18. MOTNER'S NAME (First, Middle, Maiden Surn BARBARA W. D.									KERS	SHAI)E				
TO E	BARBARA J.	O'M	EALLY			WINC). 2	21157
	20a. METNOD OF DISPOSITI	(Specify)		20b. PLACE / cemetery_cre ST.J(H CE	EM.		2/	7/9	5 5	SCH	ENE	CINY OF TO	Y,	N.Y.
	21. SHEATURE OF JUNEAU PROPERTY OF FACILITY 22. NAME AND ADDRESS OF FACILITY 25.4 E. MAIN ST 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as							GUTÝ ST.	LET	CHE ESTM	R F	UNEF	RAL MD.	HOME 21157		
	23. PATT: Enter the di shock, or hi IMMEDIATE CAUSE (find diseese pr condition resulting in death)	eart sellure.	e. Alu	t ceused the de ise on each line LQ (OR AS A CONSEC	esse	Dua	the mo	da of dy	Fau	Qu	cerdiac	Dr reepi	ratory ar	rest,	in	pproximate ntarval Between Inset and Death
CERTIFICATION	Sequentielly list condition if any, leading to immediate. Enter UNDERLY! CAUSE (Disease or injuthat initiated evente resulting in deeth) LAS	diate ING Iry	. soule	(OR AS A CONSEC (OR AS A CONSEC (OR AS A CONSEC USTO	ide	suis	no	20 81	Pr	u	uu He	011	uig Life	lu	رر،	7 day
MEDICAL	PART II. Other significe	e ve	ren Jan	ac	eid	ut	<u></u>		given in	Part i		WAS AN PERFOR		246	COMPLE OF DEAT	AUTOPSY FINDINGS BLE PRIOR TO ETION DF CAUSE TH? ES 2 (Sono
CIAN	DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:			TH (Check	only one)] UNC	ERTAIN	<u> П</u>						
PHYSICIAN:	1 VES 2 NO 27. MANNER OF DEATH 1 Notural 5	Pending	28a. DATE OF (Month, D	INJURY	28b. TIN	4 🗆 Nun	aing Nom 28c. INJ WO	RK?		_			JURY OC	CURED		
red BY	2 Accident 3 Suicide 8	Investigation Could not be determined	28a. PLACE O building,	F INJURY — At ho	me, farm,		1 \		NO	281. L	LOCATION City or Tox	N (Street a	nd Numbe	r or Rural F	loute Nun	nber,
COMPLETED			CIAN: To the best of R: On the beals of a) and ma	anner as stated.
BE		CERTIFIEF							ENSE NUM		5			E SIGNED		
0	30. NAME AND ADDRESS OF	ST WHE	COMPLETED CAUS	SE OF DEATH (ITE		Print)	 	1	Qd		W	esti	m	iste	7 +	10.
	11. DATE FILED (Month, Day,		32. REGISTRA	R'S SIGNATURE												



BALTIMORE, MARYLAND 21215-0020	A hours after death, Page 6 may be retained by the hospital or attending physicia	filled in by the funeral director, page 5 should be detached for use as the burial-tu nn, or removal.	e medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2s hours after death, Page 6 may be retained by the hospital or attending physicia	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-to be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to bunial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR		SIAIE UF I	WAKYL			ICATE				MEN	REG. NO.	E		
1. DECEDENT'S NAME (Firs	t, Middle, Last)										ATE OF DEATH		YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUM	RED	Magda 5. sex	ne In yrs. lest		lielan				Jar	nuary 27		95	2:45 PM	
038-22-6614		1 M 2 X F	n yrs. 1881 5	YRS.		DAYS	HOURS	MIN.	7. DA	TE OF BIRTH onth, Day, Year) / 18, 19	വ	Count	PLACE (State or Foreign	
9s. FACILITY NAME (If not is		J		9b. CITY, 1	TOWN OF	R LOCATI	ON OF DI		, 10, 19		NTY OF D	tonia		
Larkin Chas	e Nurs	ina Centa	er:			_	wie							George's
Larkin Chas	10b. COUNT				100 CITY TOWN OR LOCATION						111	1100	dedige 5	
Maryland		ce Georg	010	1	_	c. CITY, TOWN OR LOCATION BOWIE						•		10d. INSIDE CITY LIMITS?
10e. STREET AND NUMBER		ce dedig	5 5			OMTE	101.	ZIP CODI	F			10n CIT	ZEN OF 1	YXX YES 2 ☐ NO
4408 Orange	wood L	ane						2071						States
1 Never Married 2 Married FORCES? 1 YES 2 Y NO								NDENT C	F HISPAN	NIC ORI	GIN? (Specify Yas to Rican, atc.)	or No-	14. RACI	E — American Indian, k, White, atc.
3 Widowed 4 Dive		IF YES, GIVE Y	WAR OR DA	TES					Specify		to rican, atc.)		Spec	tty:
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working								INESS/INE	USTRY	white				
Elementery/Secondary (College (1-4 or 5	+)	life. L	o NOT u	work done dui se retired.)	ring most	t of workin	ng					
		2		Lab	Tec	hnici	an			\perp	VA Hosp	ital		
17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Lest)										1				
19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRI							Daniel 01			_	ohanna	Tuu.		
Carmen M.							Bowie,							
20s, METHOD OF DISPOSIT	PLACEAN	DDATE	OF DISPOSITI	ION (Nam	na of		-		CATION —		wn, Stats			
4 Donation 5 Other	(Specify)		Con	hesa	pea	ke Cr					-30 Bel	tsvi	lle,	Maryland
21. SIGNATURE OF FUNERA		CENSEE	0						ss of fa		vices,	РΔ		197
► Cile		1	ag	Sp		93	3 G:	ist	Aven	iue,	Silver	Spr	ing,	MD 20910
23. PART i. Enter the d ahock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eart fellure.	List only one cau	ise on ea	ich ilne.										Approximeta Interval Between Onset and Daath
Sequentially list condit if any, leading to imme ceuse. Enter UNDERLY CAUSE (Disease or inju- that initiated events resulting in deeth) LAS	diate ING Iry	С	(OR AS A											
PART II. Other algnifica	nt condition	a contributing to	death bu	it not red	eulting	in the unde	erlying	ceuse g	given in	Part i.			24b.	WERE AUTOPSY FINDINGS
C	subs	rascula	- ac	(i L	ent						PERFORI			AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
														1 Tes 2 No
DID TOBACCO U		RIBUTE TO CA						UNC	ERTAIN	<u> </u>				
25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO	U MEDICAL	HOSPITAL:				Check onl								
27. MANNER OF DEATH		1 Inpatient 2 I	INJURY	_	28b. TIM		g Home Bc. INJU		sidence		ther (Specify) DESCRIBE HOW IN	LILIBY OCC	LIBEO	
1 X Natural 5 C	Pending Investigation	(Month, D	ay, Year)			URY	WOR	K? S 2 [NO		EQUINDE HOW IN	0011 001	ONLO	
3 Culates —				44.5	e ferm e	treet, fectors	office						or Primit 5	
	Could not be determined	28e. PLACE O building,	etc. (Special	(y)	.,, .		y, onice			281. Li	OCATION (Street at ity or Town, State)	na Number	or norm	oute Number,
4 Homicide	Could not be determined	building,	etc. (Speci	(y)				nd place	and due	C	ity or Town, State)			oute Number,
4 Homicide 29s. CERTIFIER (Check only 1 CERT	Could not be determined	CIAN: To the best of	my knowle	dge, dsat	h occurre	ed at the time	e, dats s			to the	cause(s) and mani	ner as stat	ed.) and manner as stated,
4 Homicide 29s. CERTIFIER (Check only 1 CERT	Could not be determined "IFYING PHYSI ICAL EXAMINE OF CERTIFIER	CIAN: To the best of s	my knowle	dge, dsat	h occurre	ed at the time	e, dats s	ith occun		to the time, di	cause(s) and mani	ner as stat	ed. e csuse(s	
4 Homicide 29s. CERTIFIER (Check only one) 2 MEDI 29b. SIGNATURE AND TITLE	Could not be determined TIFYING PHYSI ICAL EXAMINE OF CERTIFIER	CIAN: To the best of R: On the basic of s:	my knowle	odge, dsati	h occurre	ed at the time	e, dats s	ith occun	ed at the	to the time, di	cause(s) and mani	ner as stat I dus to th	ed. e csuse(s E SIGNED) and manner as stated, (Month, Day, Year)
4 Homicide 29e. CERTIFIER (Check only one) 2 MED 29b. SIGNATURE AND TITLE 20b. NAME AND ADDRESS OF	Could not be determined IFYING PHYSI ICAL EXAMINE OF CERTIFIEF F PERSON WH	CIAN: To the best of R: On the basic of s:	my knowle	odge, dsati	h occurre	od at the time n, in my opir Print)	e, date a	29c. LICE D 4	inse num	to the time, distance of the time, distance	cause(s) and mani	dus to the	ed. e csuse(s e signed) and manner as stated. (Month, Day, Year) / 28, 1995
4 Homicide 29s. CERTIFIER (Check only one) 2 MEDI 29b. SIGNATURE AND TITLE	Could not be determined TIFYING PHYSI ICAL EXAMINE OF CERTIFIER	CIAN: To the best of R: On the basic of s:	my knowle camination SE OF DEA	ndge, daati and/or Im	h occurre	od at the time n, in my opir Print)	e, date a	29c. LICE D 4	NSE NUM	to the time, distance of the time, distance	cause(s) and mani	dus to the	ed. e csuse(s e signed) and manner as stated. (Month, Day, Year) / 28, 1995



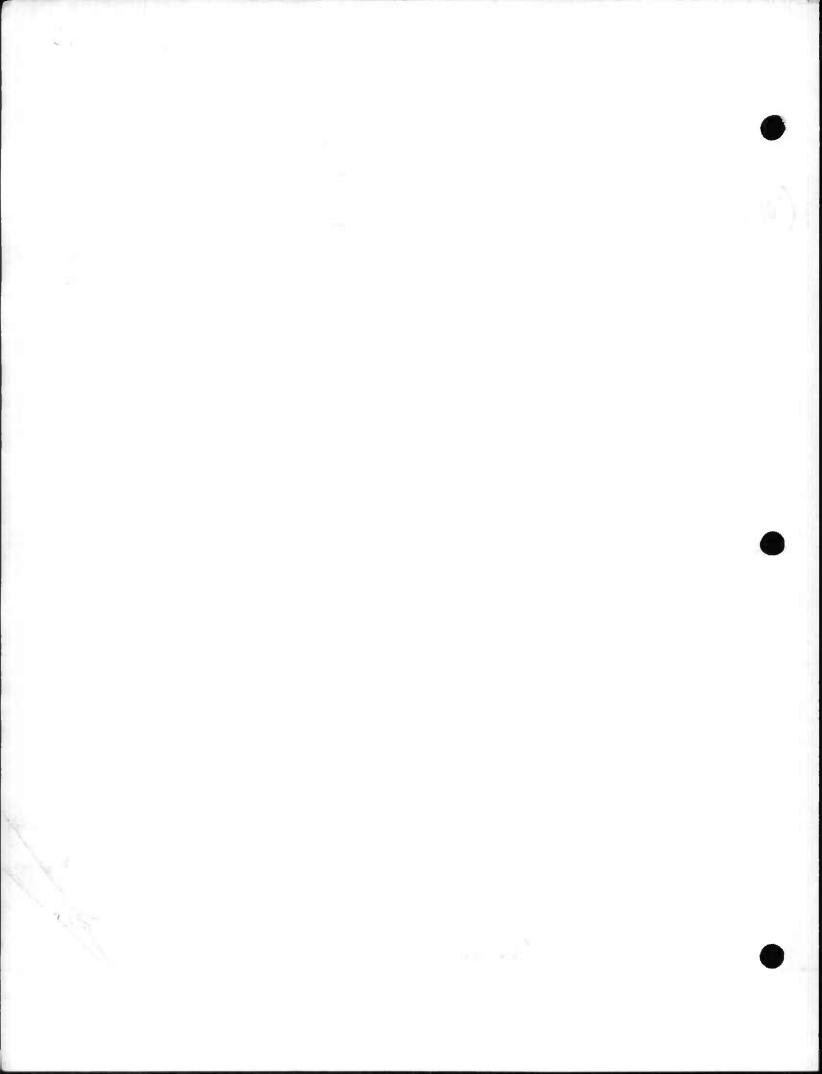
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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1 - STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	nedistran	-7				DEATH	REG. N	0.		
	1. DECEDENT'S NAME (First, Middle, Last)	OMAS_	Luge	46	Nels	son	2. DATE OF DEATH	DAY 95	YEAR 3. TIME OF E	SO A M
).).	4. SOCIAL SECURITY NUMBER 480~38-5093	5. SEX 6. AGE	E (In yrs. last birth	RS. IF UN	HS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Aug. 18,1		BIRTHPLACE (State Country)	
4	Sa. FACILITY NAME (If not institution, give a	treet and number)		9b. CITY, TOWN OR LOCATION OF DEATH					Y OF DEATH	<i>y</i> , ita
DIRECTOR	Lorien Nursing	Home		Columbia					ward	
Di l	10a. STATE 10b. COUNT	y	10.	CITY TOW	YN OR LOCATI	1001				
	Maryland How			Columbia					10d. INSIDE LIMITS?	
FUNERAL	100. STREET AND NUMBER 9100 Carriage	House Lane		101. ZIP CODE 21045				U.S	EN OF WHAT COUNTR	N7
3	11, MARITAL STATUS	12 WAS DECEDENT EVED	IN U.S. ARMED	- 1			NIC ORIGIN? (Specify)		4. RACE — American Black, Whita, etc.	1-41-
B.	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 X YES IF YES, GIVE WAR OR Korea	2 NO	NO If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 ▼ NO Specify:						ite
COMPLETED	15. DECEDENT'S EDU				L OCCUPATIO		16b. KIND OF B	USINESS/INDU		
E 1	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kir life. Do h	nd of work do IOT use retire	one during mos ed.)	t of working	333134911535		1300	
립		2	Sale	eman			Agricu	1ture	Industry	
2	17. FATHER'S NAME (First, Middle, Last)		Date	Smail	1				Industry	
		27 1					ME (First, Middle, Mald	on Sumame)		
H	Bart Nelson Lillian								Benson	
2	19a. INFORMANT'S NAME (Type/Print)		19b. MA	ILING ADDR	NESS (Street ar	nd Number or Rural	Route Number, City or To	own, State, Zip C	lode)	
-	Valerie J. Nels	on	S	ame a	s #10					
í	20a. METHOD OF DISPOSITION	20	b. PLACE AND	ATE OF DIS	POSITION (Nat	me of	OATE 20c. I	OCATION — CI	ty or Town, State	
j	20s. METHOD OF DISPOSITION 1 © Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven C6metery -1+23-95 Silver Spring									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE									
	DeVol Funeral Home 2222 Wisc. AVe., N.W., Wash. D.C.									7
	23. PART I. Enter the diseases, or	complications that cause	ed the death.	Do not en	iter the mod	de of dyling, suc	th sa cardiac or res	piratory arres	et. Aporo	ximate
	enock, or heart failure.	List only one cause on	each line.		W - Ecc	A		piratory arrot	Interve	el Between
	IMMEDIATE CAUSE (Final disease or condition	Calist	141711-	/	n. H	-/-				and Death
	resulting in death)	a	MAIN	a /	race	farne.			16	נילרחסח
		DUE TO (OR AS	A CONSEQUEN	CE OF):						
8	Sequentially list conditions,	b								
CERTIFICATION	If any, leading to immediate	DUE TO (OR AS	A CONSEQUEN	CE OF):						
5	CAUSE (Disease or Injury	c								
H	that initiated events resulting in death) LAST	OUE TO (OR AS	A CONSEQUEN	CE OF):						
E	resulting in death) CAST	d								
	PART II. Other significant condition	o contribution to develo	had also to the							
EDICAL	PART II. Other significant condition	is contributing to death	Dut not reaul	ting in the	underlying	ceuse given in	Part I, 24a. WAS / PERF	IN AUTOPSY DRMED?	24b. WERE AUTOPS	
8							1 _ YES	2 -NO	COMPLETION OF DEATH?	OF CAUSE
ME									1 TYES 2	□ NO
							_		1 .0	
₹	25. WAS CASE REFERRED TO MEDICAL				26. PL	ACE OF DEATH (C/	neck only one)			_
PHYSICIAN:	EXAMINER?	HOSPITAL:	elle. Te.		JER:		2-23-0-23			
ž.	27. MANNER OF DEATH	1 Inpetient 2 ER/Ou					6 Other (Specify)			
	1 Natural 5 Pending	28a. OATE OF INJURY (Month, Day, Year)		NJURY	28c. INJU WOF	RK?	28d. OEŞCRIBE HOV	INJURY OCCU	RED	2
B	2 Accident Investigation				1 🗆 Y	ES 2 NO				
	3 Suicide s Could not be	28e. PLACE OF INJUR building, etc. (Sp	IY — At home, to ecify)	arm, street,	factory, offica		281. LOCATION (Street City or Town, State	t and Number or	Rural Route Number,	
	4 Homicide determined						ony or rown, our	0)		
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my kno	winden doeth o	Coursed at the	na time data	and class and du		- FEE 2010		
ž I		R: On the basis of examinati								
8				rgation, in it	ny opinion, de	- Course at the	rime, detti and prace,	and dua to me	cause(a) and manner	as stated,
BE	296. SIGNATUSE AND TITLE OF CERTIFIES					29c. LICENSE NU	MBER	29d, DATE S	SIGNED (Month, Day, Y	bar)
- 11	In Ull	memo				DZIY	61	1 /-	-19-95	
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF D								
	larry Moor	e ZK		Dor	th I	h. G	olumbia	ma	15100	5
ļ	JAN 30 1005	32. REGISTRAR'S SIG	PATURE .							

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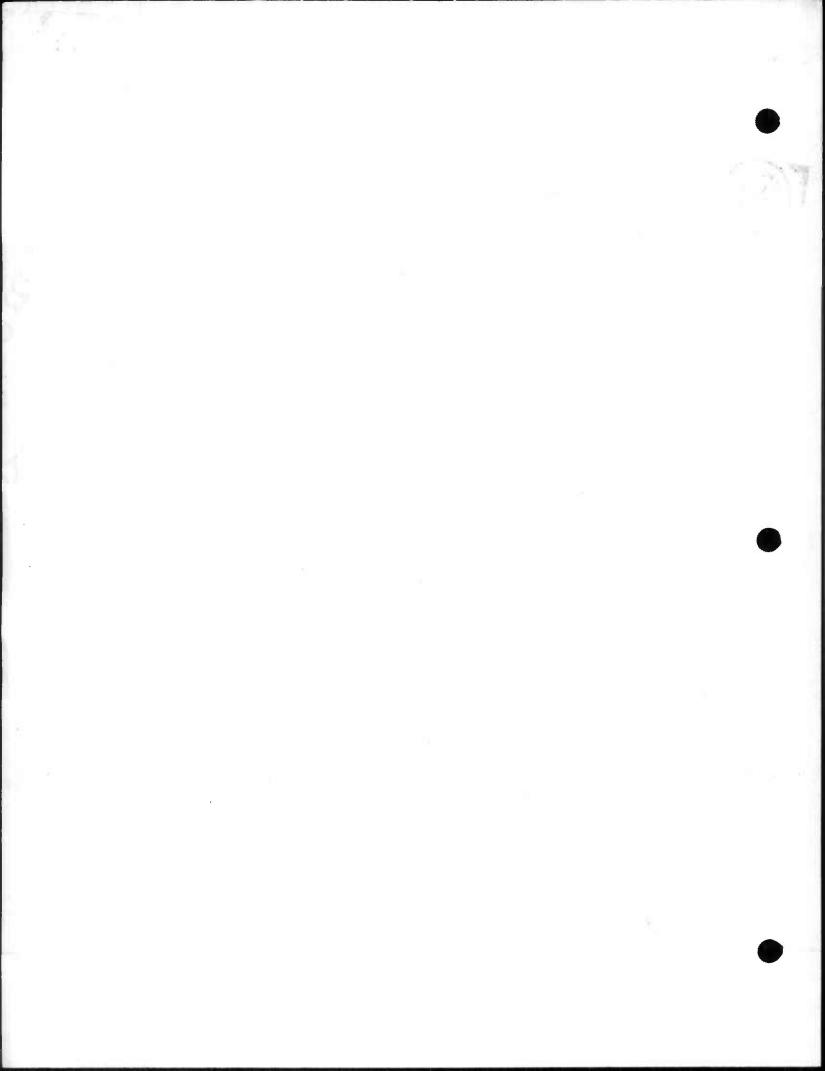


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-travent be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

REGISTRAR			ERTIF	CATE C	F DEATH		REG. NO			
1. DECEDENT'S NAME (First, Middle, Last)						2. DAT	E OF OEATH			3. TIME OF OEATH
Veronica	Μ.		Nich	ols		Jan	uary 3	0, 1	995	4:00 A M
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER 1 YE		7. DAT	E OF BIRTH	<u>-</u> -	6 BIRTH	IPLACE (State or Foreign
469-16-2630	1 M 2 X F	92	YRS.	MONTHS DA	YS HOURS MIN.		. 30 .]	1902	Count	Wisconsin
9a. FACILITY NAME (If not institution, give a	treet and number)			9b. CITY, TO	WN OR LOCATION OF D		. 50, .	-	UNTY OF D	
Kensington Garde	ens Nursi	ng Home		Κe	ensington			M	ontgo	merv
RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT			40. 0.77							
	Montgomer	17	IDE, CITY	, TOWN OR L	thesda					10d. INSIDE CITY LIMITS?
104. STREET AND NUMBER		У		Бе	101, ZIP CODE			T		1 TES 2 NO
9711 DePaul Drive	e				20817	7				Ctates
11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1			13. WAS	DECENDENT OF HISPA , specify Cuban, Mexic	NIC ORIG	IN? (Specify Yes	or No-	14. RACE	- American Indian, , White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W		50		YES 2 X NO Speci		ricen, atc.)		Speci	
15. DECEDENT'S EDU (Specify only highest grade	CATION	16a, I	DECEDENT'S	USUAL OCCUP	PATION a most of working	16	b. KIND OF BU	SINESS/IN	DUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5 +	Sw	ite. Do NOT us	a retired.)	perator/	N	lewspap	er/Z	Docto	r's Office
11			ceptio		, , , , , , , , , , , , , , , , , , , ,					s Office
17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S N	AME (First,	, Middle, Maiden	Surname)		
John Montgomery					Rose Gi					
19a. INFORMANT'S NAME (Type/Print)					eet and Number or Rural					
Beverly Marie Mcl	Namara				Drive, Be	ethes	da, Ma	ryla	nd 20	0817
20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Rem 4 Donellon 5 Other (Specify)	oval from State	20b. PLAC cemetery, o	EAND DATEO	her place) Ja	Neme of anuary 30, torium, I	183	95 I		City or To	wn, State ryland
21. SIGNATURE OF FUNERAL PERVICE LIC	ENSEE		OMOLY							
WILLES	Bouen	MO	0672	Home Wisc 3501	/Bethesda onsin Ave	-Che nue,	vy Cha Bethe	sė, sda,	Inc. Mary	ey Funeral 1357 1and 20814-
23. PART i. Enter the diseases, pr	complications thet	coused the	death. Do n							Approximate
shock, or haert failura. iMMEDIATE CAUSE (Final	LIST DRIV one ceu	se on aach iii	na.							Intarval Between Onset and Death
disease or condition resulting in death)	Pneumo	nia								1-Week
resulting in death)	٠	OR AS A CONS	EOUENCE OF):						- Mock
	b.									
Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A CONS	EQUENCE OF):						
CAUSE (Disease or injury	с									
that initiated events resulting in death) LAST	DUE TO	OR AS A CONS	EOUENCE OF):						
Tooling in duality Exist	d									-
PART II. Other significant condition	s contributing to	death but not	resulting in	the undari	ying cause given in	Part I.	24s. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
							PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
							1 YES 2	X) NO		DF DEATH?
DID TOBACCO USE CONTE	RIBUTE TO CAL	ISE OF DE	ATH YE	S II NO	X LINCEPTAL	и П				1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL				H (Check only o		., ப				
EXAMINER?	HOSPITAL: 1 Inpetient 2 I	ER/Outpatient	3 DOA	OTHER:	fome 5 - Residence	6 1 Orb	er (Specific)			
27. MANNER OF DEATH	28s, DATE OF	INJURY	28b, TIME	OF 28c.	INJURY AT		SCRIBE HOW II	NJURY OC	CURED	
1 Natural 5 Pending	(Month, De	y, mear)	INJU		WORK?					
2 Accident Investigation 3 Suicide 8 Could not be	28s. PLACE OF	INJURY At I	nome, farm, st	reet, lactory, o	office		CATION (Street of		r or Aurel A	oute Number,
4 Homicide determined	bullaing, a	etc. (Specify)				City	or Town, State)			
29e. CERTIFIER (Check only 1 X CERTIFYING PHYSIC	CIAN: To the best of a	my knowledge, o	leath occurre	f at the time of	lets and place, and due	to the se			and	
(Check only one) 2 MEDICAL EXAMINE										end manner as stated
29b. SKINATURE AND TITLE OF CHILDREN										
Jamo RM	77				D340					(Month, Day, Year)
30. MAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E OF DEATH /IT	EM 27) (7/me	Print1	1 0340.	J Z		-Jai	тиату	30, 1993
		100 300 11			Kensina	ton	Marul	and '	20802	
1. DATE FILED (Month, Day, Year)	32 REGISTRAF	R'S SIGNATURE	agut	avenue	, Kensing	COII,	Maryra	and a	20093	
FEB 03 1995 Ju	les Dandes	Kardall								

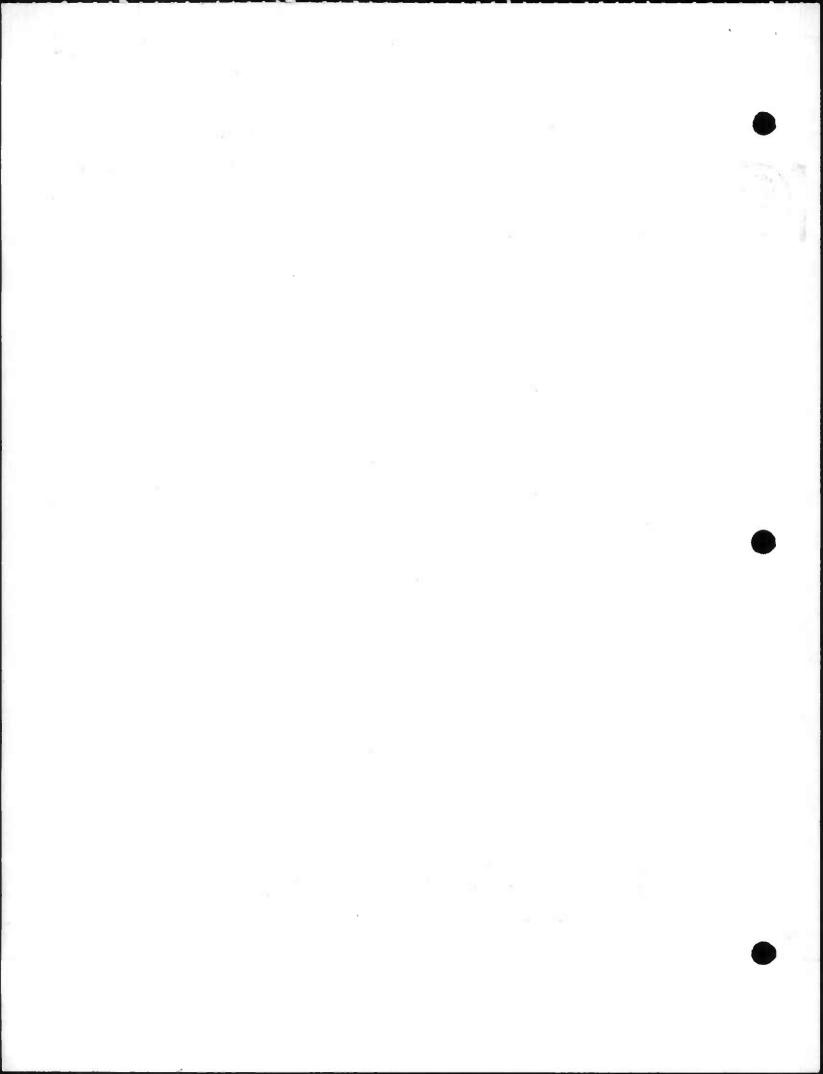


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,	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Thours after deal	INRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fun
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1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR Catherine Mae Nagel January 28 1995 10:45 5. SFY 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign Country) 7. DATE OF BIRTH (Month, Day, Year) 1905 DAYS HOURS MIN. 1 🗌 M 2 🔲 F YRS. 578-05-1353 89 August Maryland 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Presidential Woods Health Care Center Adelphi Prince George's RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery 1 X YES 2 NO Bethesda 10e. STREET AND NUMBER FUNERAL 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? burial-transit 4805 Hampden Lane 20014 U.S.A hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indien, Black, White, etc. 1 Never Merried 2 Merried If yes, specify Cuben, Mexicen, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 YES 2 NO ВY as the 3 ₭ Widowed 4 Divorced White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY use P Elementary/Secondary (0-12) eral director, page 5 should be detached Registered Nurse Medical 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Sumame) Page 6 may be retained by the to William Kline BE Unknown notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number of Rural Route Number City of Town, State, Zin Code) 0 Nancy R. Mohler Stratton Court Potomac, Maryland 20854 pe 20e. METHOD OF DISPOSITION
1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must Leudoun Park Cemetery 4 Donation 5 Other (Specify) 2/1/95 Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY oudan Francis J. Collins Funeral Home, Inc. untour 500 University Blvd., W. Sil.Spr., MD 20901 or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or haart fallura. List only one cause on each line Interval Between IMMEDIATE CAUSE (Fine) Onaet and Death cremation. the disease or condition resulting in death) event, unm-co to burial, traumatic CERTIFICATION Sequentielly list conditions. if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury or other Mental Hygiene DUE TO (DR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST injury, (PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS of Health and AVAILABLE PRIDR TO COMPLETION OF CAUSE OF DEATH? shows any 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) the State I HOSPITAL: OTHER: 1 YES 2 NO 1 Inpetient 2 I ER/Outpetient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF OEATH 28e. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCUREO 28 is marked, with Natural 1 YES 2 NO death v BY Accident Investigation 28e. PLACE OF INJURY — At home, ferm, atreet, factory, office building, etc. (Specify) 3 Suicide 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be O THE FUNERAL DIRECTOR.
TO THE FUNERAL DIRECTOR.
De filed within 72 hours after after 4 Homicide 29e CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) end menner ee stated. nination end/or investigation, in my opinion, death occured at the time, date end piece, end due to the ceuse(e) end menner ee atated. 29d. OATE SIGNED (Month, Day, Year) BE 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH DEM 27) (Type, Print, 2309 SHOREFIELD 31. DATE FILEO (Month, Day, Year)

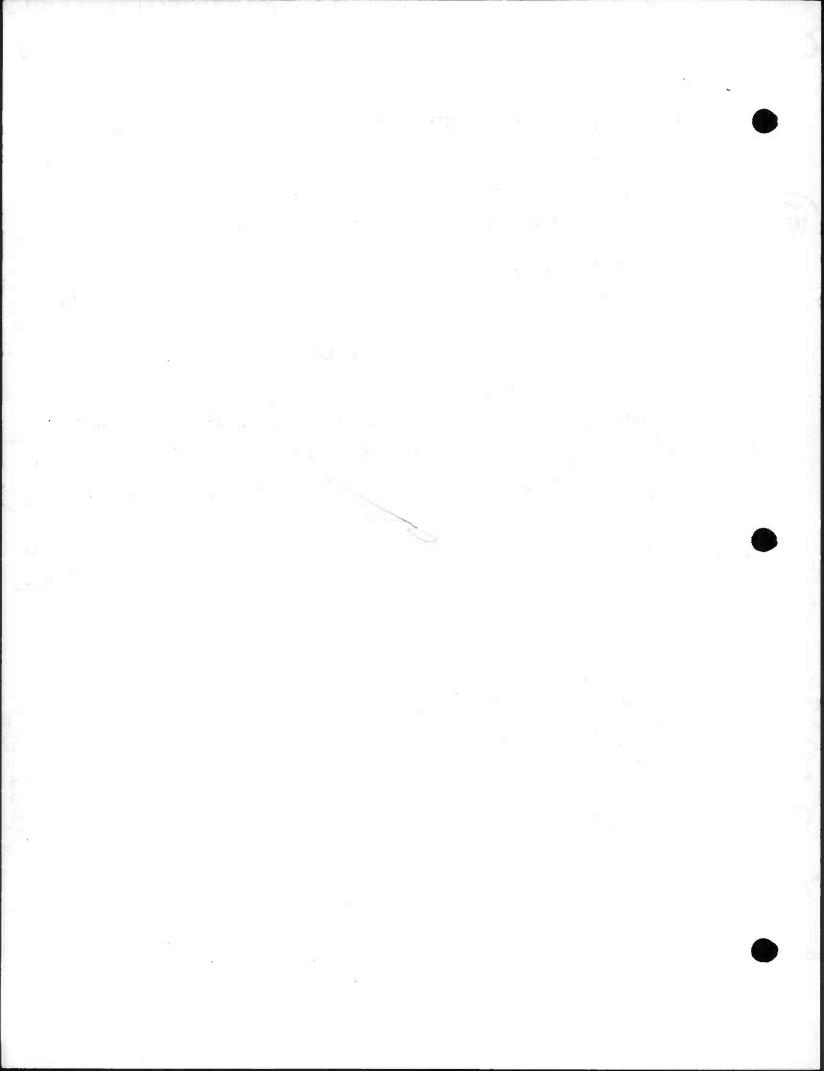
Amended # 20b STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with fours after death. Page 6 may be	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page (be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	IMPORTANT: It Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be n
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	1 - STATE REGISTRAR	STATE OF MARY		MENT OF H		MENTAL HYGIEN REG. NO.	E	
	THEOLOGE (First, Middle, Last)	P	Pfaff	2		2. DATE OF OEATH	24 199	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 577-07-8656		(In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 8-15-11	Cou	THPLACE (State or Foreign ntry) Shington. DC
OR	9a. FACILITY NAME (If not institution, give so Fallston General RESIDENCE OF DECEDENT				R LOCATION OF DE		sc. COUNTY OF	DEATH
DIRECTOR	10a, STATE 10b, COUNTY		10c. CITY	TOWN OR LOCAT		ts		10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER				ZIP CODE		200	1 YYES 2 NO
BY FUNERAL	6509 Kipling Par 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	2 TNO	If yes, spe	20747 ENOENT OF HISPAN loffy Cuban, Maxical 2 X NO Specify	IIC ORIGIN? (Specify Yea n, Puarto Rican, etc.)	Bia	CE — American Indian, lok, White, atc. White
ETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16e. OECEDENT'S 1 (Give kind of w life. Do NOT use	ork done during mos	N at of working	16b. KIND OF BUS	SINESS/INDUSTRY	
COMPLET	8th 17. FATHER'S NAME (First, Middle, Last)		Testing	Technic		C&P T		e Company
BE	Phi 19a. INFORMANT'S NAME (Type/Print)	llip Pfaff	19b. MAILING	ADDRESS (Street o		nna Matter		
10	Beatrice H. Pfaf					istrict He		
	1XXBuriel 2 Cremation 3 Rame 4 Donation 5 Other (Specify)	oval from State	ob. PLACE AND DATE Of the surrect: Resurrect:	ion Ceme	tery 1-	30-95 Cli	cation – city or inton, M	
	21. SIGNATURE OF FUNERAL SERVICE LAC	10		Geor 6160	Oxon Hi	las Funera 11 Rd. Oxo	n Hill,	Md. 20745
SATION	23. PART i. Enter the diseases, or on shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially liet conditions, if any, leeding to immediate cause. Enter UNDERLYING	a. OUE TO (OR AS	A CONSEQUENCE OF		de of dying, such		ratory erreet,	Approximata interval Batween Onset and Death Cory
CERTIFICATION	CAUSE (Disease or injury that initieted evente resulting in deeth) LAST	OUE TO (OR AS	A CONSEQUENCE OF):				
MEDICAL	PART II. Other significent condition STATE DE CLUB DID TOBACCO USE CONTI	d Mosi	OF DEATH YES	S NO	UNCERTAIN	PERFOR 1 YES 2	MED?	Ib. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER:	5 🗆 Rasidence	6 Other (Specify)		
ВУ РН	27. MANNER OF OEATH 1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME	IRY WO		26d. DESCRIBE HOW IN	NJURY OCCURED	
9	3 Suicide 6 Could not be determined	26s. PLACE OF INJUF building, stc. (Sp		261. LOCATION (Street a City or Town, State)	nd Number or Rura	I Route Number,		
COMPLET	ana l	CIAN: To the beet of my kno				time, date end placa, an	d due to the cause	o(a) and manner as atated.
TO BE	30, NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF (Dzzo	97	MANUA	W 25, 1995
	BARM WOHL 31. DATE FILEO (Month, Day, Year)	MID . 658	NATURE	m St.	SUTE B	. Bel	ai n	d Story
	JAN 3 0 1995	Julia Shooled	ir Mardally				*	



BALTIMORE, MARYLAND 21

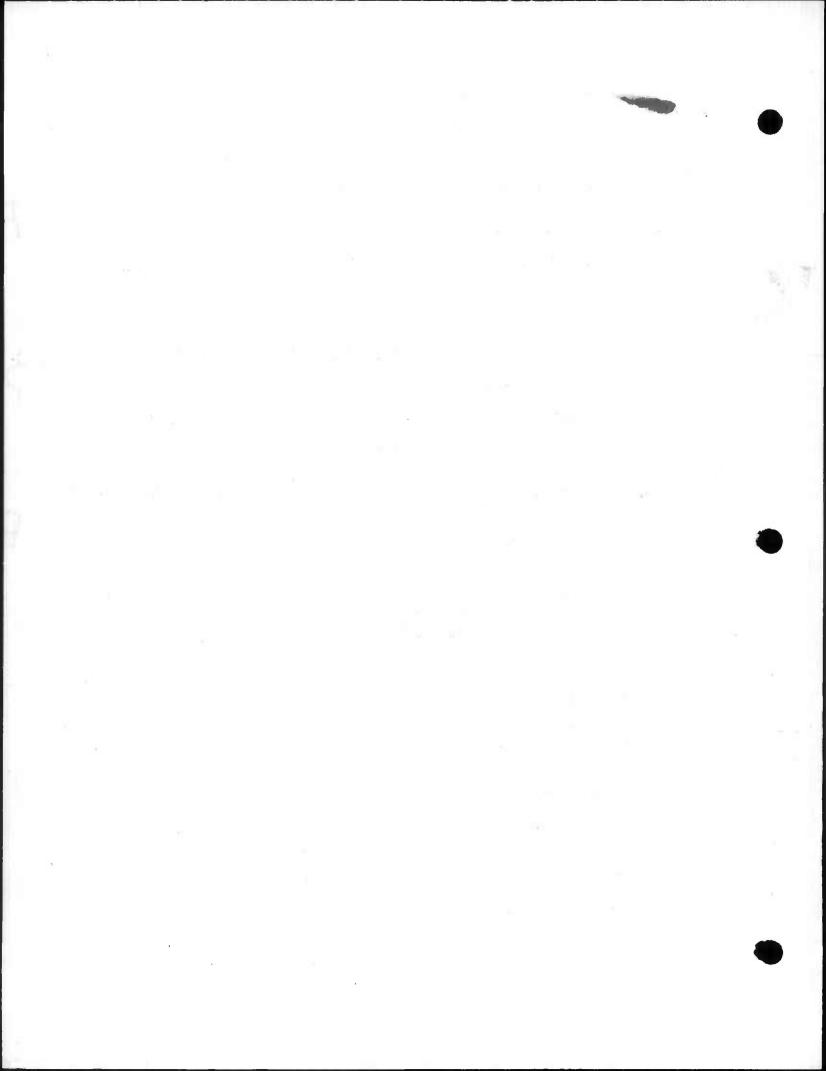
permit, Pages 1, 2, 3 should

	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Thours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached		IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYL	AND / DEPARTMENT		MENTAL	HYGIENE
	CERTIFICATE	OF DEATH		REG. NO.

	1 - FOR STATE REGIST	STATE OF MARYL	AND / DEPAR	RTMENT OF	HEALTH AND	MENTAL HYGIEN		
	1. NAME (First, Middle, Last)					2. DATE OF DEATH	AV 1740	3. TIME OF DEATN
	Mary	М.	Pa	itten		January 2	9, 1995	7:00 A. M
	000 00 6110	77	In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	NPLACE (State or Foreign
		□ M 2 🖄 F 79	YRS.	MONTHS DAYS	HOURS MIN.	March 11,		w York
m	9e. FACILITY NAME (If not institution, give street			_	OR LOCATION OF	HTAB	9c. COUNTY OF	
0	7910 Carey Branch	Drive		Fort	Washingt	on	Prince	George's
EC	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOC	ATION			10d. INSIDE CITY
2	Maryland Prince	George's		Fort W	ashingto	n		LIMITS?
AL	10e. STREET AND NUMBER				Of. ZIP CODE	11	10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL DIRECTOR	7910 Carey Bran				20744		U.S.	Α.
E		WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DI	CENDENT OF NISP	ANIC ORIGIN? (Specify Yes	s or No- 14. RAC	E - American Indian,
ΒY		IF YES, GIVE WAR OR DA			S 2 NO Spec			White
	15. DECEDENT'S EDUCATION	ON I	16a. DECEDENT'S	USUAL OCCUPAT	ION	165 KIND OF BU	SINESS/INDUSTRY	
COMPLETED	(Specify only highest grade comp Elementary/Secondary (0-12) Co	pleted)	(Give kind of a	work done during r	nost of working	100. KIND OF BU	SINESS/INDUSTRY	
릴	12		Adminis	trative	Assista	nt Dept. of	f Navv -	Federal Govt
Ö	17. FATNER'S NAME (First, Middle, Last)					AME (First, Middle, Maiden		-040141 0070
BE (Alfred T	ischer			G	ertrude Ma	y	
2	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow		
	Alfred R. Mirring		_			on Hill, Mo		
	20e, METNOD OF OISPOSITION Note: Section Note: Section Note: Section Note: Section Note: Note: Note: Section Note: Note	from State 20b.	PLACE AND DATE (etery, crematory or or PSUTTECT				CATION City or T	
	21. SIGNATURE OF FUNERAL SERVICE LICENSE		esurrect			/1/95 Clir	nton, Mar	ryland
	4 129	V-0 1		Geor	ge P. Ka	las Funeral	L Home	
_	23. PART I. Enter the diseases, or comp	alal)		6160	Oxon Hi	11 Rd. Oxor	n Hill, N	1d.20745
	shock or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death) a	only one ceuse on ea	ich line.		1 Cern		iretory arrest,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST		CONSEQUENCE OF					
CE	d							
ÄL	PART II. Other significent conditions co	ntributing to deeth bu	it not reculting i	n the underlyi	ng cause given in	Part f. 24s. WAS AN		. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă						1 YES 2	₩ NO	COMPLETION DF CAUSE OF GEATH?
M	DID TODA COO LICE CONTRIBU			. =				1 TYES 2 NO
AN	DID TOBACCO USE CONTRIBU		6. PLACE OF DEAT			N 🗆 📗		
2	EXAMINER?	SPITAL:		OTHER:		III - Programme III		
PHYSICIAN: MEDIC	27. MANNER OF DEATN	26e. DATE OF INJURY	28b. TIMI		ne 5 LA Residence	6 Other (Specify) 28d. OESCRIBE HOW I	NUMBY OCCURED	
ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	URY	ORK? YES 2 NO			
	3 Suicide a Could not be determined	28s. PLACE OF INJURY building, etc. (Special	— At home, term, s	treet, factory, off	00	261. LOCATION (Street a City or Town, State)	and Number or Rural	Route Number,
COMPLETED	29e. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: 2 MEDICAL EXAMINER: On	To the beat of my knowle the basis of examination	edge, death occurre	od at the time, dat	e end place, end du	to the cause(e) end mer	nner as stated.	e) and manner as stated
	29b. SIGNATURE AND TITLE OF CERTIFIER	m A			29c. LICENSE NU		29d. DATE SIGNED	
TO BE	30. NAME AND AGORESS OF PERSON WHO COI	MPLETED CAUSE OF OF	TH (ITEM 27) (Tors	Prints	0227	75	▶ /-30	
	Frederick G. Barr,	M.D. 2101	L Medica		Dr. #201	, Silver Sp	oring, Md	.20902
	JAN 3 0 1995	3. REGISTRAN'S SIGNA	ardall				,	



1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR		STATE OF MAR			MENT OF H		MENTA	REG. NO.	E		
t. DECEDENT'S NAME (First,	Middle, Last)				XI.E 01	DEATH	2. DAT	E OF DEATH		3. TIME OF DEATH D	_
Laurence							Fel	0. 01	1	995 1753	М
4. SOCIAL SECURITY NUMBE 200-32-0881 90. FACILITY NAME (If not ins	31	1 XM 2 F	GE (In yrs. les	YRS. MO	UNDER I YEAR	IF UNDER 24 HRS. HOURS MIN.	JUN	of BIRTH	933	8. BIRTHPLACE (State or Foreign Country) PENNSYLVANI	A
The Kent &	Оцее		Hosp			tertow			Ken	TY OF DEATH	
MARYLAND	10b. COUNTY	ANNE'S			OWN OR LOCAT					10d. INSIDE CITY LIMITS? 1 YES 2 V NO	_
900 WHITE	MARSH	ROAD				21617				EN OF WHAT COUNTRY?	
II. MARITAL STATUS Never Married 2 1 1 1 1 1 1 1 1 1		12. WAS DECEOENT EV FORCES? 1 1 1 IF YES, GIVE WAR (MED	It yes, sp	ENDENT OF HISPA ecity Cuben, Mexico 2 NO Specia	an, Puerto		or No-	14. RACE — American Indien, Black, White, etc. Specify: WHITE	
	highest grade co		(G	CEDENT'S USU live kind of work Do NOT use re	JAL OCCUPATION	ON st of working	16	b. KIND OF BUS	INESS/INDL	STRY	
Elementery/Secondary (0- 12	-12)	College (1-4 or 5+)			FARME	R		DAIR	Y FA	RMING	
JOSEPH S.	PARRY		_			16. MOTHER'S NA EL]		Middle, Malden			
FRANCES M.		Y				ARSH RO				LLE, MD	
toe. METHOD OF DISPOSITION Duriel 2 Cremetlor Donetlon 5 Other		al from State	cemetery, cre	metory or other	ISPOSITION (Ne plece) CREM	ATORY 2	2-2			Ity or Town, State	
1. SIGNATURE OF FUNERAL	SERVICE LICE	MERCE	222	(50)	NEWN.	AM FUNI B. HARI	ERAL		-		
23. PART I. Enter the dis	seases, or co		sed the de	ath. Do not	enter the mo	de of dying, suc	h ss cer	dlec or respli	ratory erre	st, Approximata	_
MMEDIATE CAUSE (Fine	el									Onset and Death	
disesse or condition resulting in death)	→ •.	JUDDEN OUE TO (OR	DEAT	4- P	ROBA	BLE ACI	ITE	Myo	INFI	ARCI instant	
		45 C 1	AS A CONSE	DUENCE OF):							
Sequentially liet condition If sny, leading to immed cause. Enter UNDERLYIN	llete	DUE TO (OR	AS A CONSEC	OUENCE OF):							-
CAUSE (Disesse or injur that initiated evente resulting in deeth) LAST		DUE TO (OR	AS A CONSEC	DUENCE OF):							_
	d.										_
PART II. Other significen		HTAL	A	resulting in the		g cause given in	Pert I.	24a. WAS AN PERFORI	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
DID TOBACCO US	SE CONTRI	BUTE TO CAUSI	OF DEA	TH YES		UNCERTAI	N 🗆			1 YES 2 NO	
5. WAS CASE REFERRED TO EXAMINER?	1	HOSPITAL:		E OF DEATH (C	Check only one)						
1 X YES 2 NO	1	28e. OATE OF INJU	RY	28b. TIME OF		e 5 Residence		or (Specify) SCRIBE HOW IN	IIII OCC	IDEA	4
t Natural 5 P	Pending nveatigation	(Month, Day, Ye	ar)	INJURY	WO	RK?	200.02	SCHIBE HOW IN	JOH! OCC	ineo	
3 Suicide 8 C		28e. PLACE OF INJ building, etc.	URY — At ho Specify)	me, ferm, stree	t, factory, office		28t. LOC City	CATION (Street er or Town, State)	nd Number o	r Rural Route Number,	
4 Homicide de	Could not be etermined	building, etc.									
9e. CERTIFIER (Check only	FYING PHYSICIA	AN: To the best of my k								1. ceuse(s) end menner es stated.	
9e. CERTIFIER (Check only	FYING PHYSICIA CAL EXAMINER:	AN: To the best of my k					time, date		due to the		

BALTIMORE, MARYLAND 21215-003 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burne be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. hours after death. Page 6 may be retained by the hospital or attending part TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

HARRY ROSS, DEPUTY MED. FFR - 3 1995

EXAM., 32 REGISTRAR'S SIGNATURE

DHMH-18 Rev 1/89

516 WASHINGTON AVE., CHESTERTOWN,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician 10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trained to be filled within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal.

INPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICAG

	1 - STATE REGISTRAR	ONTIE OF MIX	CERTIFI	CATE OF DE	ATH	REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)		0 .		2.	DATE OF DEATH		3.	TIME OF DEATH
	Char	es	1 ORTS	M.		1-29-1°		rear .	8:00P M
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. last birthday)	IF UNDER 1 YEAR IF U		DATE OF BIRTH		BIRTHPLA	CE (State or Foreign
	160-09-1069	1 XM 2 - F	76 YRS.	NONTHS DAYS HOU	PIS MIN.	(Month, Day, Year) 8 - 30 - 19	918	Pa.	
	Sa. FACILITY NAME (If not institution, give a	treet and number)		9b. CITY, TOWN OR LO	CATION OF DEATH		9c. COUNT		1
OR	Anne Arundel	Medical '	Ctr.	Annai	polis		Ann	e Ar	undel
DIRECTOR	Anne Arundel RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT				70110		211111	CHI	under
E			177	TOWN OR LOCATION					LIMITS?
	MD Ann 100, STREET AND NUMBER	e Arunde	L A1	nnapolis					YES 2 NO
FUNERAL				10f. ZIP (17.5.5				COUNTRY?
NE	443 Delso Ct.				21401			SA	
E	1 Never Married 2 Married	12. WAS DECEDENT E FORCES? 1 7 IF YES, GIVE WAR	YES 2 NO		NT OF HISPANIC C Cuban, Maxican, Pu	RIGIN? (Specify Yes uarto Rican, etc.)	or No- 14	Black, WI	American Indian, sita, atc.
ВУ	3 Widowed 4 Divorced			1 🗆 YES 2 💢	NO Specify:		047	Specify:	771- 2
	15. DECEDENT'S EDU	CATION	16a, DECEDENT'S L	SUAL OCCUPATION		16b. KIND OF BUS	INESC (INC.) IS	TRV	White
E	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of we	rk done during most of w	rorking	TOOL KIND OF BOS	MESS/MDUS	H	
7	10	conege (1-4 or 5 +)	Instru	nent Mecl	hanic	Chem	ical	Fact	OTV
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		11100101			First, Middle, Malden		1 4 0 0	OL J
BE C	John		Porte		Anna	_	ees		
	19a. INFORMANT'S NAME (Type/Print)			DDRESS (Street and Nu		Number, City or Town	, Stata, Zip Co	ode)	
임	Kenneth Porte	r	443	Delso Ct	. Annar	olis, N	MD 21	401	
	20e. METHOD OF DISPOSITION 1 ☐ Burlel 2 ☑ Cremetion 3 ☐ Ram	oval from State	20b. PLACE AND DATE OF	DISPOSITION (Name of		DATE 20c. LOC	CATION — CIT	y or Town,	Stata
	4 Donation 5 Other (Specify)		Metro C	cematory	2	2-1 Cai	tonsv	ille	, MD
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22. NAME AND AD	DRESS OF FACILIT	4	95 Ri	tchi	e Hwy.
	March Chi	Suna		Barrane	co FH S	Severna			
	23. PART . Enter the diseeses, or o	complications that cr	sused the deeth. Do no					-	Approximata
- 1	ehock, or heert fallure. IMMEDIATE CAUSE (Final	List only one ceuse	on each line.					"	Interval Between Onset and Death
	diseese or condition	(KSSP	Fally) ,				i	11 - 14 ·
	resulting in death)	DUE TO (OR	AS A CONSEQUENCE OF)						100
z I		. Asp	Prems					į	
일	Sequentially list conditions, If sny, leading to immediate	DUE TO (OR	AS A CONSEQUENCE OF)	,					
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury	· Mul	TPLE C	WA->					
	that initiated events resulting in death) LAST	DUE TO (OR	AS A CONSEQUENCE OF)						
		d							
CAL	PART II. Other significent condition	s contributing to dec	eth but not resulting in	the underlying cau	se given in Part				E AUTOPSY FINDINGS
2	CUA					PERFORI		COM	LABLE PRIOR TO IPLETION OF CAUSE
ME					_	10.129			YES 2 TINO
ż	DID TOBACCO USE CONTI	RIBUTE TO CAUS	E OF DEATH YES	□ NO 🗗 UI	NCERTAIN [,
ĕ.	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH	(Check only one)					
PHYSICIAN:	1 YES 2 40	HOSPITAL:		OTHER:	Rasidence 6 🗆	Other (Specify)			
H	27. MANNER OF DEATH	26s. DATE OF INJ (Month, Day, Y	URY 26b. TIME		T 26d	. DESCRIBE HOW IN	JURY OCCUP	ED	
BY	1 Netural 5 Pending 2 Accident Investigation		18 1	16.11	2 NO	UVZ			
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF IN building, atc.	JURY — At home, tarm, str (Specify)	et, factory, office	26t,	LOCATION (Street ar City or Town, State)	nd Number or	Porel Route	Number,
COMPLETED			<u> </u>	7			Pr	7	
뢰			knowledge, death occurred						
	2 MEDICAL EXAMINE	R: On the beals of axemi	nation and/or investigation,	in my opinion, death o	coured at the time,	, data and place, and	dua to the c	ause(a) and	menner as stated.
H H	204 SIGNATURE AND TITLE OF CERTIFIER			29c.	LICENSE NUMBER		29d. DATE 9	GNED Mon	th, Day, Year)
	Jun ()			K	133064		▶ //:	3014	5
- 1	30. NAME AND ADDRESS OF PERSON WHI	COMPLETED CAUSE C	E DEATH (ITEM 27) (Since 6	rint)			- 1		
Į.	1 . D - A	iA	DEATH (ITEM 21) (1) Po. 1	,	1 0				
	660 Kida	us Au	e Su	ta 121	Hones	no ma	12140	1	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	e Su	6 121	Honog	ns me	12140)	
	660 Kida	3. REGISTRAR'S	e Su	4 121	Ang	mc ca	12140)	

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, P.O. BOX 68760	eath certificate he executed with
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RDS, P.O. BOX 68760	hat the death certificate he executed with
ORDS, P.O. BOX 68760	that the death certificate he executed with
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RECORDS, P.O. BOX 68760	requires that the death certificate he executed with
L RECORDS, P.O. BOX 68760	law requires that the death cartificate he executed with
AL RECORDS, P.O. BOX 68760	he law consists that the death contificate he even that with
TAL RECORDS, P.O. BOX 68760	. The law comittee that the death cartificate he evented with
VITAL RECORDS, P.O. BOX 68760	AM: The law comings that the death cardificate he executed will
* VITAL RECORDS, P.O. BOX 68760	MIN. The law comires that the death certificate he executed will
DF VITAL RECORDS, P.O. BOX 68760	VCIPIAN. The law consists that the death certificate he executed will
OF VITAL RECORDS, P.O. BOX 68760	DHVCICIAN: The law consists that the death cartificate he executed with
N OF VITAL RECORDS, P.O. BOX 68760	C DHVCIPIAN: The law requires that the death certificate he executed with
ON OF VITAL RECORDS, P.O. BOX 68760	TIMIC DEVOLUTION. The law consists that the death cartificate he executed with
ION OF VITAL RECORDS, P.O. BOX 68760	BIDIBLE DEVELOPENT The law requires that the death certificate he executed with
ISION OF VITAL RECORDS, P.O. BOX 68760	ITEMINIAL DUVELINAM. The law comittee that the death cartificate he evented with
VISION OF VITAL RECORDS, P.O. BOX 68760	ATTENDING DEVOICION. The law remaines that the death certificate he executed with
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	OD STERNING DAYS CIAN. The law consists that has hearth nestificate he executed within 3 hours often death Dane 5 men he estated has been deather and the consistence of the consistence

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within at hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burn be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

	FOR 1 - STATE REGISTRAR		MARYLAND /	DEPAF ERTIF					MENTA	HYGIEN REG. NO.			
	1. DECEOENT'S NAME (First, Middle, La	est)							2. DATE	OF DEATH	v	YEAR	3. TIME OF DEATH
	CLARENCE W	OODROW		POT	ΓS				FEB		995	TEAR	1:03 P.M.M
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs, les	t birthday)		R 1 YEAR	IF UNDER	~~~	7. DATE	OF BIRTH		6. BIRTH	IPLACE (State or Foreign
1	220-10-0649	1, M 2 □ F	79	YRS.	MONTHS	DAYS	HOURS	MIN.	FEB	2.5 19	115	Countr D II'N	INA.
	9a. FACILITY NAME (If not institution, gi				9b. CIT	Y, TOWN C	R LOCATI	ON OF DE	1 2 20 10	23 1,	_ E	ITY OF D	
E I	MEMORIAL HOSPIT.	AL		CUMBERLAND							ALL	EGAN	ΝY
DIRECTOR	RESIDENCE OF DECEDENT												
H	10a. STATE 10b. COL				.,	OR LOCAT							10d. INSIDE CITY
	MARYLAND A	LLEGANY		Cr	MBE	RLANI)						1 V YES 2 NO
A	10e. STREET AND NUMBER					101	ZIP CODI	E			10g. CITI	ZEN OF Y	WHAT COUNTRY?
ER	470 BALTIMORE	STREET				2	21502				U.S	.A.	
FUNERAL	11. MARITAL STATUS		T EVER IN U.S. AR		13.	WAS DEC	ENDENT O	F HISPAN	NIC ORIGIN	? (Specify Yea	or No—	14. RACE	E — American Indian,
												k, White, etc.	
В	3 Widowed 4 □ Divorced						2 (2),100	apacity	у.			Speci	"Y WHITE
	15. DECEDENT'S E (Specify only highest gi		16a. DE	CEOENT'S	USUAL O	CCUPATIO	N .		16b.	KIND OF BUS	INESS/IND	USTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5	Hfo.	ive kind of a Do NOT us	se retired.)	auring mo	st or workin	g					
4	12		CUM	BERLA	ND S	STREE	T DE	РТ	S	TREET	DEPT		
COMPLET	17. FATHER'S NAME (First, Middle, Last)		10011							Aiddle, Maiden			
	ALBERT ROY POT	TS				TTTT	TE E	RT ANC	HE CII	NCED	M A NT		
19e INFORMANT'S NAME (Reselled)													
2	MARTHA LASHLEY											,	
	20a, METHOO OF DISPOSITION		20b. PLACE					E 5.	OATI		CATION —		ZLAND 21532
	1XXBuriel 2 Cremation 3 R	amoval from State	cemetery, cre FAIRVI	matory or o	thar placa	און אטוונג ידי די אי	neor TTTD	0 10	OF			-	
	21, SIGNATURE OF FUNERAL SERVICE	LICENSEE A A	FALKVI	LEW C			D ADDRES			INGLE	SMIT	H PA	١.
	9	9 M =	1							RAL HO	ME		
	Nale o	X-IIIeu	ul		40)4 DE	CATU	R ST	TREET	CUMBE	RLAN	D MA	RYLAND
	23. PART I. Enter the diseases, ehock, or heert fellu	or complications the	t ceused the de	eth. Do r	not enter	the mo-	de of dyi	ng, auc	h es card	lac or reepi	ratory err	eet,	Approximate
	IMMEDIATE CAUSE (Final	re. List only one cet	ise on eech line			/	/					- and the same	Interval Between Onset and Death
	diseese or condition resulting in death)	20	*	Lan	d.	Jail	ing						1 21. male
	resorting in death)	DUE TO	(OR AS A CONSEC	DUENCE O	F):	0							1200 odel
_			(COV	0								10000
ō	Sequentially list conditions, if any, leeding to immediate	b. DUE TO	(OR AS A CONSEC	DUENCE O	F):								1947
ERTIFICATION	cause. Enter UNDERLYING			Se	6501)							Dwels
Ĕ	CAUSE (Disease or injury that initieted events	DUE TO	(OR AS A CONSEC	DUENCE O	F):								
E	reaulting in death) LAST	a a											1
8		- d.											
A	PART II. Other significent condit	iona contributing to	death but not r	esuiting	in the u	nderlying	cause g	liven in	Pert I.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS
8		Ka	ituit	>	1	we	19			1 YES 2	16		COMPLETION OF CAUSE DF DEATH?
													1 YES 2 NO
PHYSICIAN: MEDICAL	DID TOBACCO USE CON	NTRIBUTE TO CA	USE OF DEA	TH YE	s X	NO [UNC	ERTAIN	v 🗆				
¥	25. WAS CASE REFERRED TO MEDICAL			E OF DEA			0110		, 🗀				
Sic	EXAMINER?	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHE!		5 □ Pa	aldence	8 Other	(Specify)			
≟ ∥	27. MANNER OF DEATH	26a. DATE OF	INJURY	28b. TIM	E OF	28c, INJI	_	alderice	_	CRIBE HOW IN	JURY OCC	URFO	
	Natural 5 Pending	(Month, D	ay, Year)	INJ	URY	WO	RK?	NO				01120	
BY	2 Accident Investigation	28a PLACE O	F INJURY — At ho	me, ferm.	street, fac			,	281 1.004	ATION (Street a	nd Number	or Purel 6	Bouda Mumbar
	4 Homicide 6 Could not determined	building,	atc. (Specify)	,,		,			City o	or Town, State)	TO THUMBUR	or nurer n	toole Nonioer,
	29a. CERTIFIER				_		_				-		
<u></u>	(Check only	IYSICIAN: To the best of	my knowledge, de	ath occum	ed at the t	lime, deta	and place,	and dua	to the cau	se(s) end men	ner ee atate	ıd,	
COMPLET	2 MEDICAL EXAM	INER: On the beels of a	minution and/or I	nvestigatio	n, in my o	opinion, d	ath occur	ed at the	time, date	and place, and	due to the	cause(a	a) and manner ea stated.
	29b, SIGNATURE AND TITLE OF CERTI	FIER L	5				29c. LICE	NSE NUN	MBER		29d. DATE	SIGNED	(Month, Day, Year)
H	111/4	John T	1-			İ					▶ Fel		The sixth
임	30. NAME AND ADDRESS OF PERSON	5000					D36	700					

21502

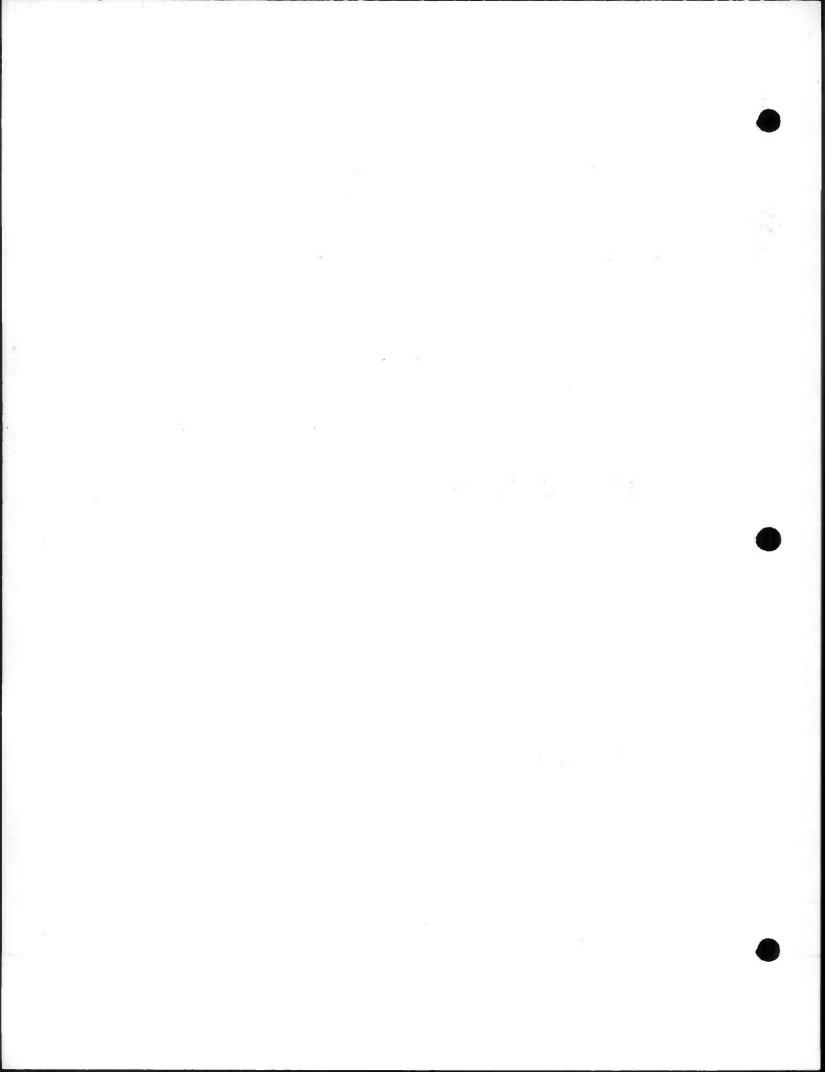
CUMBERLAND MARYLAND

30. NAME AND ADDRESS OF BERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

9 WILLIAMS STREET
32 REGISTRAR'S SIGNATURE
LIE Shutter Raylall

STREET

DR. VIK POONAT
31. DATE FILEO (Month, Day, Year)
FEB 0 7 15



•	STATE REGISTR
4	1. DECEDENT'S
Ì	Alexa

		OL	HIIF	CAI	E OF	DEATH	_		i. NO.				
1. DECEDENT'S NAME (First, Middle, La								DATE OF DEA	DAY		YEAR	3. TIME OF DEAT	Н
Alexander S. P								inuary		, 19) h
	6. SEX	6. AGE (In yrs. last		MONTH	ER 1 YEAR	HOURS MI		7. DATE OF BIRTH (Month, Day, Year)			8. BIRTH Countr	IPLACE (State or For ry)	reign
216-25-1035	1 ☑ M 2 □ F	5	YRS.					ig 22,	19			1and	
a. FACILITY NAME (If not institution, gi						OR LOCATION O	F DEATH				NTY OF D		
7 Treworthy Ro	ad			Gā	aithe	rsburg				Mont	gome	ry	
DESIDENCE OF DECEDENT 10b. COU	NTY		10c. CIT	y, TOW	OR LOCA	TION						10d, INSIDE CITY	
Marena and Marel												LIMITS?	
Maryland Mont	domery		Ga:	the	ersbu	of ZIP CODE				40= CIT	TEN OF Y	1 TYES 2 THAT COUNTRY?	NO
7 Treworthy Ro	ad				- "	20878				USA		WIAI COOKINIT	
1. MARITAL STATUS	12. WAS DECEDENT	FVFR IN U.S. ARE	MED	1	3 WAS DE	CENDENT OF HI	SPANIC O	DICING (Case	Hou Man a	- 10-1		E American ledin	
Never Married 2 Married Widowed 4 Divorced	FORCES? 1	YES 2 N	o		If yes, s	pecify Cuben, Me 8 2 1 NO S	exican, Pu			JI 140	Speci	E — American India k, White, atc. lly: White	111,
15. DECEDENT'S E			CEDENT'S					16b. KIND (OF BUSI	NESS/IN	DUSTRY	MILLOC	
(Specify only highest gr Elementary/Secondary (0-12)	college (1-4 or 5 +	Ma	ve kind of v Do NOT us	vork dor e retired	ne during m f.)	ost of working							
0	Compaction of 0.4		i1d					Ch	i1d				
FATHER'S NAME (First, Middle, Last)						16. MOTHER'S	NAME (F			umame)			
Harry Perper						Debr			110000	H IN THE			
a. INFORMANT'S NAME (Type/Print)		196	MAILING	ADDRE	SS (Street	and Number or R			or Town.	State, Zie	Code)		
Harry Perper		7				Road, G						3	
Da. METHOD OF DISPOSITION		20b. PLACE A	NDDATE	OF DISP	OSITION (A	lame of		DATE 20	Oc. LOC	ATION	City or To	rwn. Stele	
Buriel 2 ☐ Cremation 3 ☐ R ☐ Donation 8 ☐ Other (Specify) _	emovel from State	King D	avid	ther plac	moria	al Gard	ensi	1/30 F	Ta 11	SC	hurcl	h. VA	
. SIGNATURE OF FUNERAL SERVICE	ПСЕНВЕЕ			2	2. NAME A	ND ADDRESS O	F FACILIT	Y					
Sel.	4					rd Sage Rockvi						MD20852	
3. PART I. Enter the diseases,	or complications that	caused tha dea	ath. Do n									Approxima	
ahock, or heart fallu	e. List only one caus	se on each lina.										Interval Be	
MMEDIATE CAUSE (Final	Toutende	a h manalarr	(0										Deat
esulting in death)	a. Leukody	OR AS A CONSEC	UENCE OF	ldVa	111)							3 yrs	
	- Pneumon		na. Panas	,								1 1/2	rale o
equantially list conditions, any, leading to immediate	-	OR AS A CONSEO	UENCE OF	F):								1/6	NIZO
ause. Enter UNDERLYING													
AUSE (Disease or injury nat initiated events	DUE TO	OR AS A CONSEO	UENCE OF	F):									
esulting in death) LAST	4												
ART II. Other significant condit	ions contributing to	death but not re	eaulting i	in the	underlyir	ng cause give	in Part	i. 24a. W	AS AN A	UTOPSY	24b	WERE AUTOPSY FIL	
100								101	ES 2	NO		OF DEATH?	AUSE
												1 YES 2 N	NO
WAS CASE REFERRED TO MEDICAL EXAMINER?					26. F	LACE OF DEATH	(Check or	nly one)					
1 YES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTH 4 N		me 5 Preside	nce 6 🗆	Other (Specif	y)				
MANNER OF DEATH	28a. DATE OF (Month, Da		28b. TIM	E OF	28c. IN	JURY AT		. DESCRIBE		JURY OC	CURED		
1 Natural 5 Pending Investigation		y, reary	INJ	URY		ORK? YES 2 NO							
2 Accident a Could not	28e. PLACE OF	INJURY At hor	me, farm, s	street, f	ectory, offi	ce	261.	LOCATION (Street an	d Numbe	r or Rural F	Route Number,	
4 Homicide determined		etc. (Specify)						City or Town,	State)				
. CERTIFIER 1 CERTIFYING PH	YSICIAN: To the bast of	my knowladaa da	th occur	wd as 41-	e time de	a and place and	due to the	a 6mm=/-1	ad me		to d		
onel	INER: On the basis of ex											t) and manner as at	tate of
	1	- Indiana in a second in	Janyario	, 111 111	, opinioni,			Jack and big	oe, and				
b. SIGNATURE AND TITUE OF CERTI	lier mp					29c LICENSE	910			29d. DAT	E SIGNED	(Month, Day, Year)	-
NAME AND ADDRESS OF PERSON		F OF DEATH STEE	1 271 /3	Optool		V	110				1/3	1173	
						T.77	1	0000	c	700	1	/	
Peter B. Shere	I, M.D., 39	94/ rerr		υrı	ve,	wneaton	, MD	2090	0-4	109		1	
	88 8501050	200 010111							_				$\overline{}$
DATE FILED (Month, Day, Year)	32 REGISTRAI	R'S SIGNATURE	. 11										

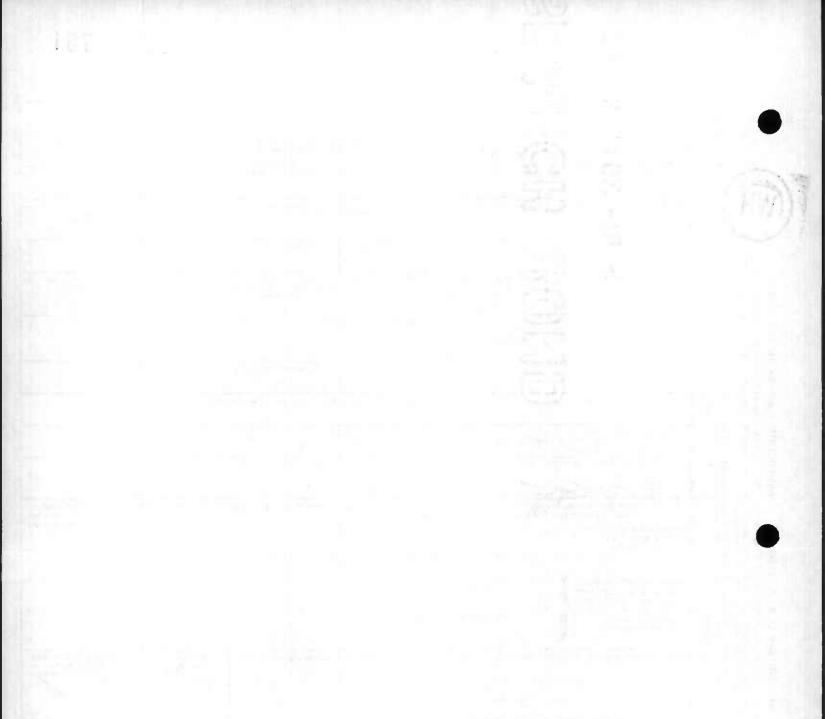
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Fours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-16 Rev 1/89



FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - REGISTRAR		CI	ERTIFI	CATE C	F DEATH	1116111	REG. NO			
1. DECEDENT'S NAME (First, Middle, Last)						2. DAT	E OF DEATH			3. TIME OF DEATH
France	s Linscot	t Polen	1			Тат	nuary 2	AY 7	YEAR QQ5	9:45 A M
4. SOCIAL SECURITY NUMBER	5. SEX 6	. AGE (In yrs. les	t birthday)	IF UNDER 1 YEA	AR IF UNDER 24 HRS.	7. DAT	E OF BIRTH	, , ,	8. BIRTH	IPLACE (State or Foreign
578-07-6871	1 🗆 M 2 🙀 F	79	YRS.	TS HOURS MIN.	100	nth, Day, Year)	Country			
9e. FACILITY NAME (If not institution, give :	street and number)			9b. CITY, TOV	WN OR LOCATION OF D	Sept. 27,1915			JNTY OF D	DWA
4537 Windsor La	ine			Bo:	thesda			1.5		
RESIDENCE OF DECEDENT				De	ciresua			MO	ntgo	mery
10a. STATE 10b. COUNT	Υ		10c. CITY,	TOWN OR LO	CATION					10d, INSIDE CITY LIMITS?
Maryland Mon	tgomery			Betl	nesda				j	1 YES 2 NO
10e. STREET AND NUMBER					101. ZIP CODE			10g. CI	TIZEN OF Y	WHAT COUNTRY?
4537 Windsor	Lane				20814	ļ.		Uni	ted :	States
11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AR	MED	13. WAS	DECENDENT OF HISPA	NIC ORIG	IN? (Specify Yes			E — American Indian, k, White, atc.
1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE WAR		10		, specify Cuban, Maxic YES 2 ← NO Speci		Rican, atc.)		Speci	
3 🗵 Widowed 4 Divorced										White
15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(Gi	ive kind of wo	SUAL OCCUP	ATION most of working	16	b. KIND OF BU			
Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT use	retired.)			Nation	al I	nsti	tutes
12		R	esear	ch Ass	sistant		of	Hea	1th	
17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	AME (First,	Middle, Maiden	Sumame)		
Henry Josiah L	inscott				IN.	[elli	e Burg	е		
19a. INFORMANT'S NAME (Type/Print)		198	b. MAILING	ADDRESS (Stre	et and Number or Rural	Route Nur	nber, City or Tow	n, State, Zi	p Code)	
Patricia P. Selb	У	7	18 7t	h Aver	ue North,	Sur	fside	Beac	h. S(29575
20a. METHOD OF DISPOSITION 1 ☐ Burlal 2 ☆ Cremation 3 ☐ Ram		20b. PLACE	AND DATE OF	FDISPOSITION	(Neme of 1/30/	95 DA	TE 20c. LO		City or To	
4 Donation 5 Other (Specify)	lovat from State	Monto	metory or oth	erpiece) 7 Crem.	atorium,	Tnic.	Beth	- had	Ma	ryland
21. SIGNATURE OF FUNERAL SERVICE LI	GENSEE			22. NAM	AND ADDRESS OF FA	ACILITY				
▶ /2 , / ¥	- h	MO	0198	эаоя	ert A. Pum	phre	y Fune	ral	Home/	/
23. PART I. Enter the pisesses, or	complications that	anaad the de	ath Da a	7557	Wisconsi	n Av	e Bet	hesd.	a MD	20814-3501
ahock, or heart failure.	List only one ceuse	on each line	atn. Do no	t enter the	mode of dying, suc	ch as ca	rdiac or respi	ratory as	reat,	Approximate interval Between
IMMEDIATE CAUSE (Final disease or condition										Onset and Death
resulting in death)		cardial			n					ļ
		R AS A CONSEC	-							
Sequentially list conditions,		onary A			ase					
If any, leading to immediate cause. Enter UNDERLYING		erioscl								
CAUSE (Disesse or Injury	с.									
that initiated events reaulting in death) LAST	DOE 10 (0	R AS A CONSEC	DUENCE OF)	•						
	d									
PART II. Other algnificent condition	ns contributing to de	esth but not n	esulting in	the underly	ying cause given in	Pert I.	24s, WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
							PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
							1 TYES 2	⊠ NO		DF DEATH?
DID TOBACCO USE CONT	DIRLITE TO CALL	SE OE DE A	TH VE	N NO	☐ IINICEDTA	NI D				1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL	KIDUTE TO CAU			(Check only o						
EXAMINER?	HOSPITAL:			OTHER:						
27. MANNER OF DEATH	1 Inpatient 2 I E				lome 5 X Residence	_				
1 X Natural 5 Pending	(Month, Day,		28b. TIME INJU	RY	INJURY AT WORK?	28d. DE	SCRIBE HOW II	NJURY OC	CURED	
2 Accident Investigation					YES 2 NO					
3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF I building, etc	NJURY — At hou c. (Specify)	me, farm, str	reet, factory, o	ffica		CATION (Street a	ind Numbe	r or Rural R	loute Number,
29a. CERTIFIER (Check only 1) CERTIFYING PHYSI	ICIAN: To the best of m	y knowledga, der	ath occurred	at the time, d	late and place, and due	to the ca	luse(a) and man	ner ea ats	ted.	
one) 2 MEDICAL EXAMINE) and manner as stated.
299. SIGNAPURS AND TITLE OF CERTIFIE		10	,		29c. LtCENSE NUI					(Month, Day, Year)
C 2015 1	Araba	m	2		D1102					y 30, 1995
30. NAME AND DERESS OF PERSON WH	O COMPLETED CAUSE	OF DEATH STEE	1 27) (Nna 4	Print)	1	_		,		,
					_					
John B. Umhau, M.	1 32/REGISTRAR'S	S. SIGNATURE		venue	. Chevy Cl	nase	. Maryl	and	208	15
JAN 31 1995	Julia Dav	dear Ren	ball							ļ
- 1000			4- 4							



TO BE COMPLETED BY FUNERAL DIRECTOR LE

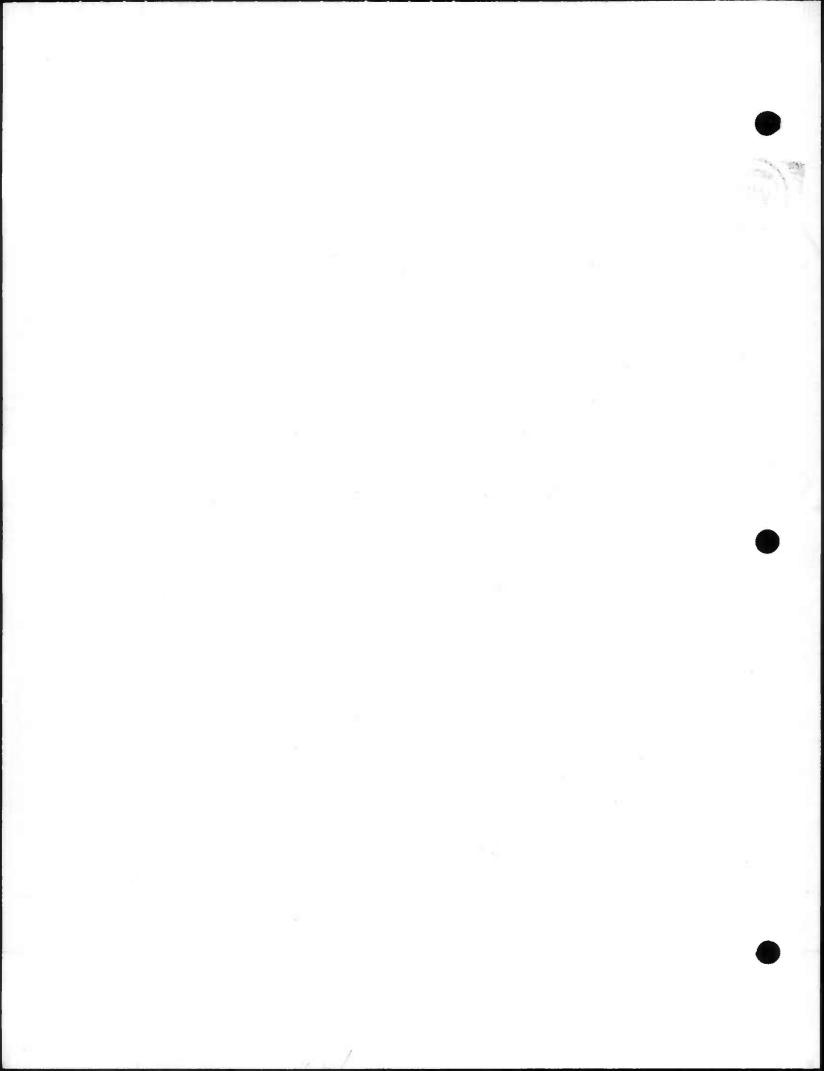
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withings. Incurs after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or remoral.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-18 Rev 1/89



Amended #17, 2/1/95 MRT Montgomery 35, 14:783

	1 - STATE REGISTRAR	STATE OF MARYLAND	/ DEPAR ERTIF	ICATE	OF H	DEAT	AND I	MENTAL HYGIE REG. N			5
	1. DECEDENT'S NAME (First, Middle, Last)	RAHADIA P	A.D	V ~				2. DATE OF DEATN	DAY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In vir. In	71	Ne	-			January 2	9, 19		3:00 A M
- 1		5. SEX 6. AGE (In yrs. In 1 M 2 X F 81	YRS.	IF UNDER	DAYS	IF UNDER	MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb. 10,	1012	8. BIRTH	PLACE (State or Foreign
	9a. FACILITY NAME (If not institution, give stre			9b, CITY	TOWN C	R LOCATI	ON OF DE			INTY OF D	"Maryland
S.	Montgomery Genera	l Hospital				1ney		-,		ylan	
5	RESIDENCE OF DECEDENT 100. STATE 100b. COUNTY		I in a			Ė					
FUNERAL DIRECTOR	Maryland Mo	ontgomery		Rock							10d. INSIDE CITY LIMITS? 1 YES 2 NO
PAL	100. STREET AND NUMBER				101	ZIP CODI			10g. CIT	IZEN OF V	VHAT COUNTRY?
NE I	14804 Rocking Spr					208				USA	
B	1 Never Married 2 Married 3 X Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. AI FORCES? 1 YES 2 X IF YES, GIVE WAR OR DATES	RMED NO	1	f yea, spe	ENDENT Cociety Cuba 2 X NO	n, Mexica	IIC ORIGIN? (Specify) n, Puerto Rican, etc.)	ea or No—		E — American Indian, k, Whita, etc. My: White
	15. DECEDENT'S EDUCA (Specify only highest grade co	ompleted) ((ECEDENT'S	work done o			a	166. KIND OF 8	USINESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	ne ma	se retired.)				Own	Home	2	
8	17. FATHER'S NAME (First, Middle, Lest)	1. D. 1.1.1. G			Ä	- 11V		ME (First, Middle, Melde			
BE	Andrew Josp Josep 19a. INFORMANT'S NAME (Type/Print)							th France			
2	Elizabeth P. Merg							loute Number, City or R Drive Roc			D 20853
	20a. METNOD OF DISPOSITION 1 N Burlel 2 Cremation 3 Remove 4 Donation 6 Other (Specify)	20b. PLACE cometery, on FOTT	AND DATE OF DISPOSITION (Name of emetery 2/1/95 Brentwood,								
	21. SIGNATURE OF FUNERAL SERVICE LICEN	NSEE				D ADDRES	S OF FAC	CILITY			
	Clinothyx	Canobell.		5	00 U	nive	rsit	llins Fun y Blvd. W	.,Sil	.Spr	, Inc. .,MD 20901
	23. PART i. Enter the diseases, or col ahock, or heart failure. Lie	mplications that caused the di at only one cause on each line	eath. Do r e.	not anter	the mo	de of dyi	ng, suct	n aa cardiac or rea	piratory ar	reat,	Approximate interval Between
	iMMEDIATE CAUSE (Final disease or condition	DNem	l n n	in	a						Onset and Death
	resulting in death) a.	DUE TO (OR, AS A CONSE	OUENCE D	Ri .			-				Jamo
z		Cardia	CY	76	RX	2 5	T				1 sec.
일	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSE	QUENCE OF	F):							Sec.
5	CAUSE (Disease or injury	DUE TO (OR AS A CONSE	OHENCE OF	1			- 1				JUAN
CERTIFICATION	that initiated events resulting in death) LAST	Attri	0). -	Fi	br	···	lATA	\		UNKNOW
CAL	PART II. Other aignificant conditions,	contributing to death but not	resulting	In the un	derlying	cause g	lven in i	Part I. 24a, WAS A	N AUTOPSY	24b.	WERE AUTOPSY FINDINGS
MEDIC/	Dement	ja i	51	rol	<	e		1 TYES	NO NO		AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF DEA	ATH YE	SIL	VO \Box	UNC	EDTA	17/			1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERENCED TO MEDICAL	26. PLA	CE OF DEAT	N (Check o	only one)	0.10		X			
VSIC	1 TES 2 NO	HOSPITAL: Inputient 2 - ER/Outputient 3	□ DOA	OTHER		5 🗆 Re	sidence	6 Other (Specify)			
F	27. MANNER OF DEATH 1. Netural 5 Pending	26g. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF URY	28c. INJI WO	RIC?		26d. DESCRIBE NOW	INJURY OC	CUREO	
à	2 Accident Investigation	284 PLACE OF IN HIRTY	The form	M does do se		ES 2 [NO NO				
TE	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — At he building, etc. (Specify)	ziite, iBIM, I	MITTER, ISCIC	ory, office			26f. LOCATION (Stree City or Town, Stat		r or Rural R	toute Number,
₩ N											

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician.

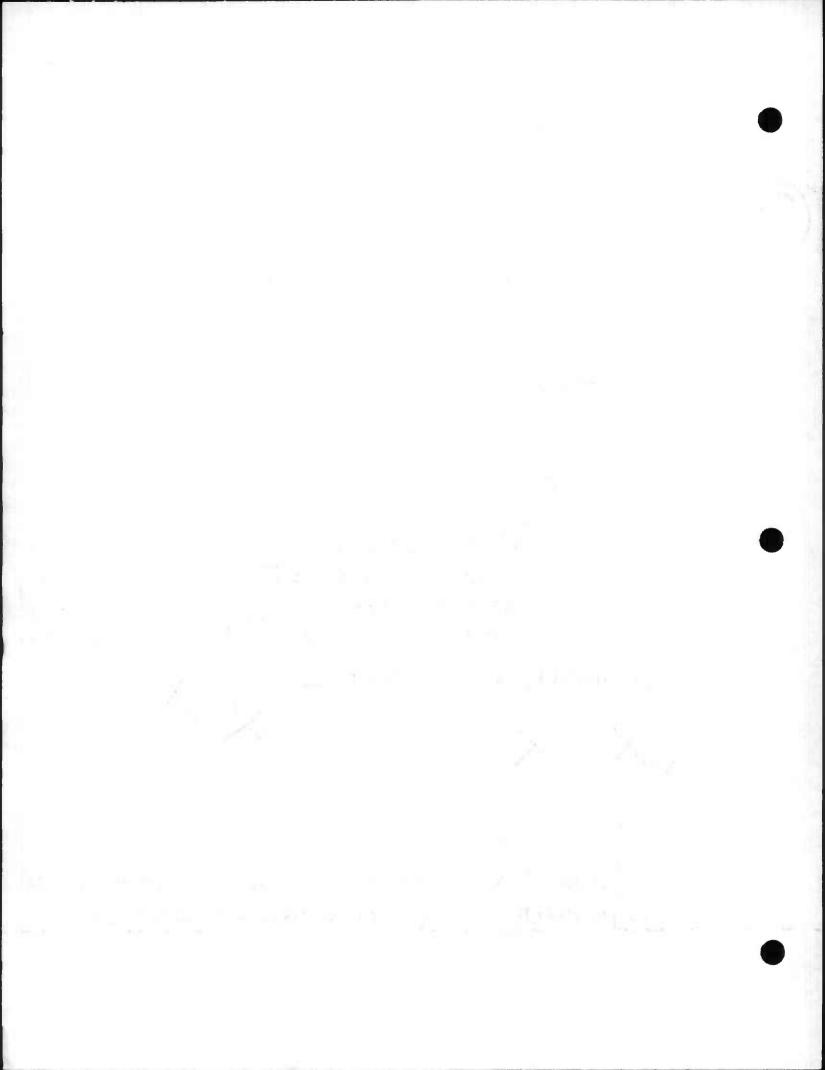
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral directic page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN; MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

29d, DATE SIGNED (Month, Day, Year)



FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

REG. NO.

	REGISTRAR		CERTIFIC	ATE OF	DEATH	REG	NO.		
	1. DECEDENT'S NAME (First, Middle, Last)		700	-	2. DATE OF DEA	TH DAY	WEAD	3. TIME OF DEATN	
1	HEI	LEN	L. POSE	Υ		Februar	y 5,199	95	4:00 A. M
		SEX 6. AGE		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRT (Month, Day, W Oct. 13	'H ear)	8. BIRTN Countr	NPLACE (State or Foreign ny) ryland
	9e. FACILITY NAME (If not institution, give street a	and number)	9	b. CITY, TOWN	OR LOCATION OF DE			INTY OF D	-
STOR	Citizens Nursing	Home		Fre	derick		F:	redei	rick
DIRE	Maryland 10b. county	Frederick	10c. CITY, T	OWN OR LOCA	Fred	erick	10d, INSIDE CITY LIMITS? 1 X YES 2 NO		
FUNERAL DIRECTOR	10e. STREET AND NUMBER	E. Seven	th St.	10	21	701		what country?	
BY FUN	1 Never Merried 2 Merried	WAS DECEDENT EVER IF FORCES? 1 YES, GIVE WAR OR D	2 NO	If yes, sp	ENDENT OF HISPAN ecify Cuban, Mexical 2 of NO Specify	n, Puerto Rican, et	ify Yes or No— c.)	14. RACE Black Speci	E — American Indian, k, White, atc.
	15. DECEDENT'S EDUCATIO (Specify only highest grade comp	ON history	18e. DECEDENT'S US (Give kind of work	UAL OCCUPATION	ON pot of weeking	16b. KINO 0	F BUSINESS/IN	DUSTRY	Diack
COMPLETED		ollege (1-4 or 5+)	Domesti	etired.)	as or working	Pri	lvate-d	omes	tic
8	17. FATNER'S NAME (First, Middle, Last)				18. MOTNER'S NAI	ME (First, Middle, M	faiden Surname)		
BE C		ward	Green		Nanc			and1	es
2	190. INFORMANT'S NAME (Type/Print) Albert A. Radclif:	fe			w Ave./				701
	20e, METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Removal 4 Donetion 5 Other (Specify)	20	b. PLACE AND DATE OF Consider, cremetory, or other Fairview	DISPOSITION (N	ame of	DATE 20	c. LOCATION —	City or To	
- 1	21. SIGNATURE OF FUNERAL SERVICE LICENSE				ND ADDRESS OF FAC	CILITY Stuaf	fer Fu	nera	1 Home
	Barreno /	elene	d)	1			k,Md.21702		
	23. PART Letter the diseases, or complete the complete th		d tha death. Do not lech lina. Proof The A CONSEQUENCE OF:				reapiratory an	rest,	Approximata interval Between Onset and Daath
CERTIFICATION	Sequantially list conditions, if any, laading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DOE TO (ON AS	A CONSEQUENCE OF):	rocus	-80erb	Des			10 years
Ö	PART II. Other aignificant conditions co	ntributing to death i	out not resulting in t	he underlyin	a course share in	Boot I Day yo		-	
EDICAL		Tributing to death t	- Tot labuting in	nie underlyni	g cause givan in	PE	AS AN AUTOPSY ERFORMED? ES 2 NO	246.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<u>×</u>	DID TOBACCO USE CONTRIBU	ITE TO CAUSE O	DE DEATH YES	ПИОГ	1 LINICEDTAIN				1 YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL	J.L TO CAUSE C	26. PLACE OF DEATH		- OTTCERTAIN	,			
SIC		SPITAL: Inpatient 2 ER/Out		THER:	e 5 🗆 Residence	8 Other (Specifi	0		
Y PHYSICIAN:	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJ		28d. DESCRIBE N		CURED	
TED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide datermined	28e. PLACE OF INJURY building, etc. (Spe	— At home, ferm, stre- cify)	et, fectory, offic	•	28f. LOCATION (S City or Town,	itreet and Number State)	r or Rural F	Route Number,
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: 2 MEDICAL EXAMINER: On								e) end menner es stated.
H	29b. SIGNATURE AND TITLE OF CERTIFIER	onles			29c. LICENSE NUM	BER			(Month, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WHO CO				miole Mil	2170			-,
	B.O. Thomas /		Second St.	rrede	erick, Md	. 2170	T		
	31. DATE FILED (Month, Dey, Yeer) FFR 1 0 1995	32. REGISTRAR'S SIGN	GOS-Rardally						
	FED T VIVO		*1						

1 - STATE REGISTRAR		SINIE UI II	//An r La	CERTIF					MENIA	REG. NO.	t .		
1. DECEDENT'S NAME (First	t, Middle, Last)								2. DATE	OF DEATH			3. TIME OF DEATH
JOHA	1 JUSE	EPH	PARR	٧					JAI	ง้ ∋ั		995	0850 M
4. SOCIAL SECURITY NUMBER		5. SEX		yrs. last birthday) IF UNDE	ER 1 YEAR	IF UNDER		7. DATE	OF BIRTH	_	a BIRTHE	PLACE (State or Foreign
577-14-09	, , , , ,	1 🔀 M 2 🗌 F	86	YRS.	MONTHo	DAYS	HOURS	MIN.	Jul	y 14,	190	Country,	. Carolin
9e. FACILITY NAME (If not in						TY, TOWN C			EATH			INTY OF DE	ATH
Holy Cros		pital			S:	ilve	r Sj	prir	ng		MC	ONTGO	OMERY
RESIDENCE OF DEC	10b, COUNTY			10c. C	TY TOWN	OR LOCAT	TION .						10d, INSIDE CITY
Maryland		gomery				ver	1000	ina					LIMITS?
10e. STREET AND NUMBER		JUNICLY			211		SPT.				100 CIT		1 YES 2 NO
1511 Whea	ton La	ane						2090	12			U.S.	
11. MARITAL STATUS		12. WAS DECEDEN			13	. WAS DEC	ENDENT C	OF HISPAI	NIC ORIGII	N? (Specify Yes	or No —	14. RACE	- American Indian
1 Never Merried 2 3 Wildowed 4 Divo	Merried	FORCES? 1 IF YES, GIVE W	X YES	2 NO		If yee, spe	ecify Cube 2 X NO	en, Mexice	en, Puerto	Ricen, atc.)		Black, Specify	White, etc.
	CEDENT'S EDUCAT by highest grade co.		- 1	(Give kind of	S USUAL (OCCUPATIO	ON est of working	ng	16k	. KIND OF BUS	SINESS/INE	DUSTRY	
Elementary/Secondary (0	J-12)	College (1-4 or 5 +	+)										
llth				Secu	rity	y Gu						veri	nment
17. FATHER'S NAME (First, M		0								Middle, Maiden			
Walter C						_		reton					
John J. P	,,,	Jr. (Sc	on)_							ber, City or Yow shing			20011
20e. METHOD OF DISPOSIT		rel trom State		LACE AND DATE	E OF DISPO	SITION /Na			DAT	V		City or Tow	
4 Donation 5 Other	r (Specify)		- Li	ery, crematory or nColn	Mer	mori				4 Su	itla	and,	MD
21. SIGNATURE OF FUNERA	L BERVICE LICEN	ISEE /		1		NAME AN				****			
2 ron	98 IC	· Du	ONE	len	RC	OCKV	TLLE	E. M	4D	HOME 20850	•		
23. PART I. Enter the d ahock, or h	eart fallure. Lis	mplications that ist only one cau	it caused tuse on eac	he desth. Do	not ente	r the mo	de of dy	Ing, suc	h ss can	diac or respi	retory sr	rest,	Approximats interval Between
IMMEDIATE CAUSE (Fir disease or condition resulting in death)	nal → a		· · · · · · · · · · · · · · · · · · ·	CONSEQUENCE	1	66	·~						Onset and Death
Sequentially list condit if sny, leading to imme cause. Enter UNDERLY CAUSE (Disesse or inju that initiated events resulting in death) LAS	diate ING ury	Cov	(Off AS A C		on J.	7	0	no p	phen	Jux			4 monts
PART II. Other algolfica	int conditiona	contributing to	deeth but	not reauiting	In the u	ınderiyinç	g cause	given in	Pert I.	24a, WAS AN	AUTOPSY		WERE AUTOPSY FINDINGS
		None							_	PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO U	SE CONTRI	BUTE TO CA	USE OF	DEATH Y	ES 🗹	NO E	1 UNC	CERTAII	N 🗆				1 1 1 1 2 2 1 110
25. WAS CASE REFERRED T	O MEDICAL			. PLACE OF DE				Photo at the	,				
EXAMINER?		HOSPITAL:	ER/Output	lent 3 🗆 DOA	OTHE 4 - Nu	R: ursing Home	e 5 🗆 Re	esidence	8 🗆 Othe	er (Specify)			
	Pending	28e. DATE OF (Month, Di	INJURY	28b. TII		28c. INJI WO			_	SCRIBE HOW II	NJURY OC	CURED	
3 Suicide 8	Could not be datermined	28s. PLACE O building,	F INJURY — etc. (Specify	- At home, farm,	, atreet, ter				28t. LOC City	ATION (Street e or Yown, State)	nd Number	or Rural Ro	oute Number,
	OBterminad												
		AN: To the best of On the basis of ex											end menner as stated.
296. GRATURE AND TITLE	OF CERTIFIER	1					29c, LICI	ENSE NUM	MBER	3	29d. DAT	E SIGNED (Month, Day, Year)
30. NAME AND ADDRESS OF	F PERSON WHO	COMPLETED CAUS		H (ITEM 27) (7/10	e. Print)			132	81			1/31	18)
M Wajee	1 Kh	97 1	w.	12016	-	eor	nà	p	6	Le	for a	mp 2	20902
FEB 03 19	195 Jul	32 AEGISTRA	on-Rand	all		0			,				

nours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Month, Day, Yber) 03 1995

32 REGISTRAR'S SIGNATURE
Driver Randall

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. 15

DHMH-16 Rev 1/89

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILEO (MONTH)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
R. TREHAN 50 W Edwardon Dy + 401,

MEGISTRAR'S SIGNATURE

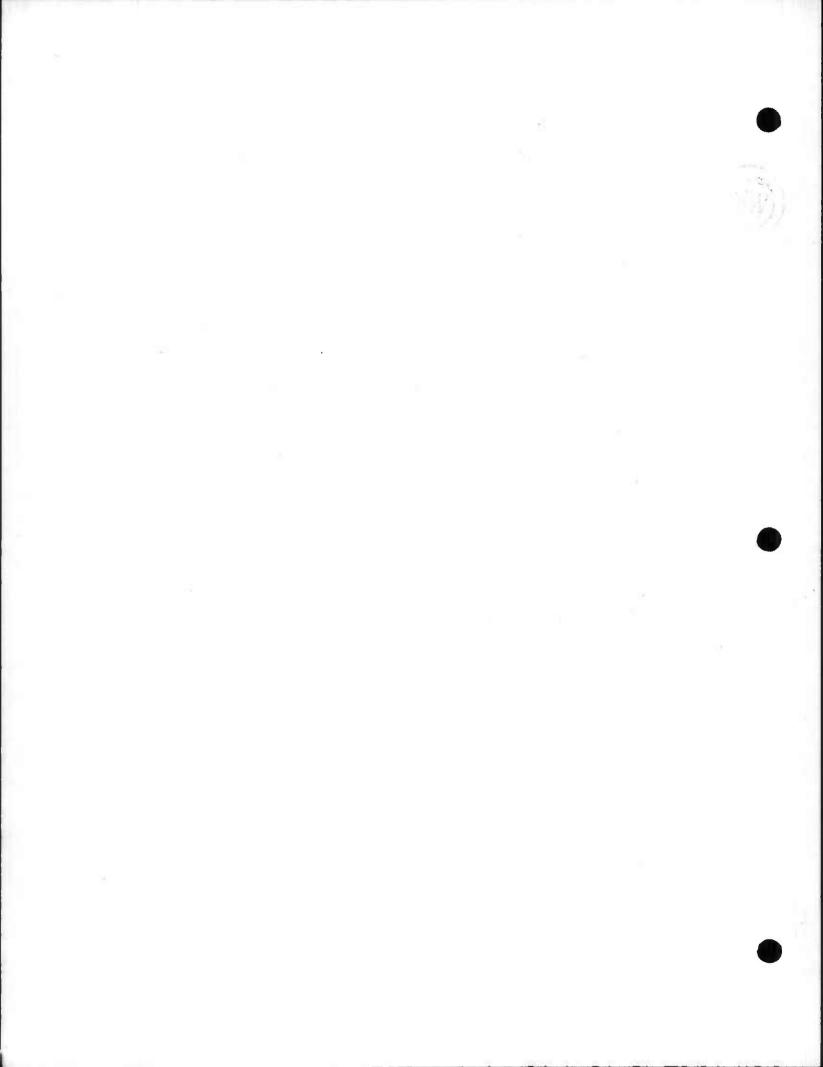
FOR	STATE OF MARYLA	IND / DEPARTA	ACUT OF H	EAITH AND	MENTAL HVCIEN	-	01.00
1 - STATE REGISTRAR	OIAIL OI MARILLE	CERTIFIC			MENIAL HYGIEN REG. NO		
1. DECEDENT'S NAME (First, Middle, Lost) Milton	3,	Prather	- 6	Se.		26, 199	3. TIME OF DEATH
	XXM2□F 68	140	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jan 21,	1 (BIFITHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give str Shady Grove Ad	oet and number) Iventist Ho	spital	Rockvi	R LOCATION OF DI		9c. COUNTY	
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	**	10c. CITY. TO	OWN OR LOCAT	ION			10d. INSIDE CITY
New Jersev Atl	antia						LIMITS?
10a. STREET AND NUMBER	aultic	AL	lantic	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
1330 Mediterran	ran Ave,			08401		II.S	S.A.
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 X NO	If yes, spe		NIC ORIGIN? (Specify Yearn, Puerto Rican, atc.)	or No— 14.	RACE — American Indian, Black, Whita, atc.
15. DECEDENT'S EDUC. (Specify only highest grade of		16a. DECEDENT'S USI	done during mos	N at of working	16b, KIND OF BU	SINESS/INDUST	TRY
Elementary/Secondary (0-12)	College (1-4 or 5+)	ine. Do NOT use re	tired.)				
12th Grade		Security	Guar				sino.
Roger Prat	her			Lena	ME (First, Middle, Maiden Brown	Sumame)	
19a. INFORMANT'S NAME (Type/Print)	(Sister)	19b. MAILING AD	DRESS (Street a		Route Number, City or Tow	n. State. Zip Coc	(a)
Ms Lois Jean Pr	ather				Germanto		
20a, METHOD OF DISPOSITION 1 Parial 2 Cremation 3 Remote 4 Donation 5 Other (Specify)	val from Stata AS	PLACE AND DATE OF D	ISPOSITION (Na	ne of	DATE 20c. LO Y2/2 Gen	CATION - CITY	or Town State
21. SIGNATURE OF FUNERAL SERVICE LACE	ENSEE		22. NAME AN	D ADDRESS OF FA	CILITY		
+ STATE P	busin	los			neral Hon		
23. PART I. Enter the diseases, or co	omplications that caused	the death. Do not	anter the mod	IN . Wasi	has cardiac or read	ratory arrest	Ckville, Md
ahock, or heart fallure. L. IMMEDIATE CAUSE (Final	la only one cause on ea	ch ilna.		,			Interval Batween Onset and Death
	CARCINOHA	OF THE	LUN	G WITH	METAST,	2324	
resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF):					
Sequentially list conditions.	RESPIRI		AILU	RE			Iday
If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):					
CAUSE (Disease or Injury C.	DUE TO (OR AS A	CONSEQUENCE OF):					
that initiated events resulting in death) LAST		oonsecoence or j.					
PART II. Other significant conditions	contributing to death bu	t not resulting in t	he underlying	cause given in	Part I. 24a, WAS AN	ALITOPSY	24b. WERE AUTOPSY FINDINGS
	behucture			saase	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
					1 YES 2	MO	OF DEATH?
DID TOBACCO USE CONTR	IBUTE TO CAUSE OF	DEATH YES	П № П	UNCERTAIN	<u>_</u>		t YES 2 NO
25. WAS CASE REFERRED TO MEDICAL	2	6. PLACE OF DEATH (
	HOSPITAL:	tient 3 DOA 4	THER: ☐ Nursing Home	5 Residence	8 Other (Specify)		
EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Outpe						
1 U YES 2 NO 27. MANNER OF OEATH	1 Inpatient 2 ER/Outpa 28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJU		28d. DESCRIBE HOW II	JURY OCCURE	EO
1 UYES 2 NO	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	M 1 Y		28d. DESCRIBE HOW II	JURY OCCURE	EO
1 VES 2 NO 27. MANNER OF OEATH 1 Natural 5 Pending	28a. DATE OF INJURY	28b. TIME OI INJURY	M 1 Y	RK?	28d. DESCRIBE HOW II 28f. LOCATION (Street a City or Town, State)		
27. MANNER OF OEATH 1	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OI INJURY — At home, farm, stree y) dge, death occurred at	M 1 Y	IK? ES 2 NO	281. LOCATION (Street a City or Town, State) to the cause(a) and man	nd Number or R	iural Route Number,
27. MANNER OF OEATH 1	28s. DATE OF INJURY (Month, Day, Year) 28s. PLACE OF INJURY building, atc. (Specil	28b. TIME OI INJURY — At home, farm, stree y) dge, death occurred at	M 1 Y	IK? ES 2 NO	281. LOCATION (Street a City or Town, State) to the csuse(a) and man time, data and place, an	nd Number or R	iural Route Number,

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit in the filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. **BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68760

Rockwell Mp 20552



1	-	STATE	Αſ
I	1. D	ECEDENT'S	N

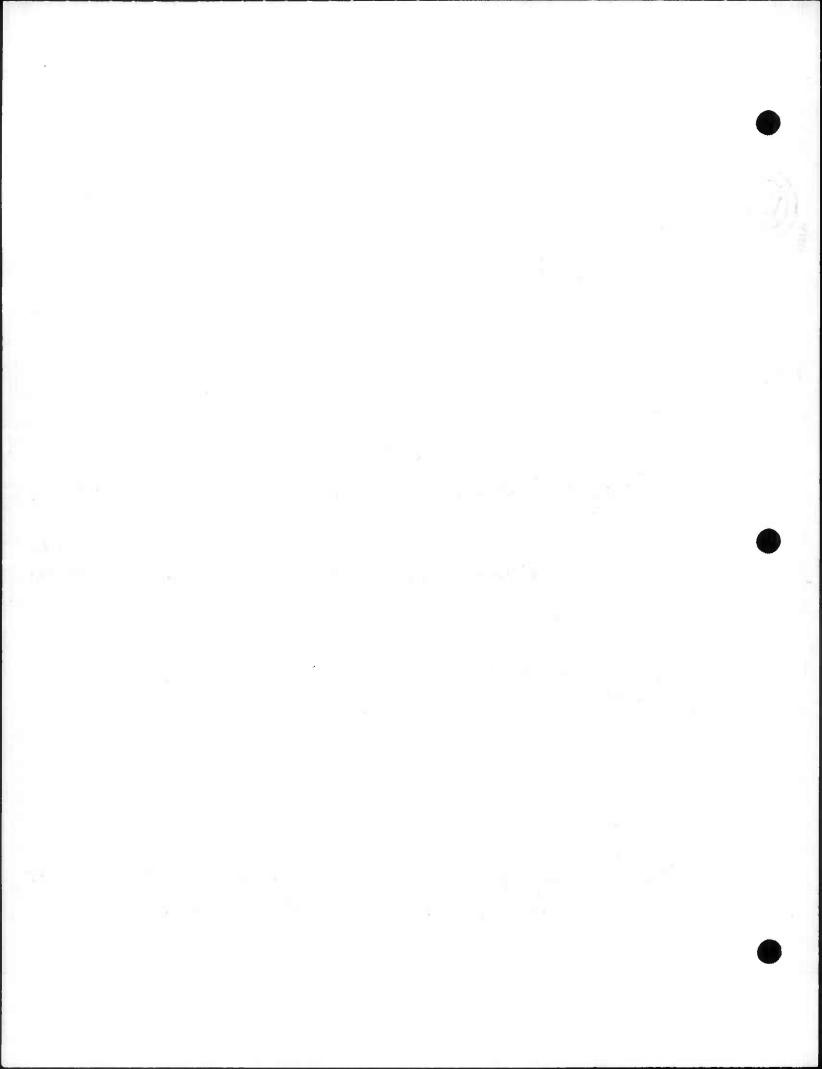
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICAE

	1 - STATE REGISTRAR	CERTIF	CATE OF	DEATH	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEA	TH
	Arthur Berry	•	erry				995 3:00	рм
	The second secon	(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	T	8. BIRTHPLACE (State or I	
		O YRS.	MONTHS DAYS	HOURS MIN.	July 7, 19	924	Massachuset	ts
	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN	OR LOCATION OF D			ITY OF DEATH	
Ю	Shady Grove Adventist Hospita	1	Rockvi	11e		Mo	ontgomery	
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	100 CIT	Y, TOWN OR LOC	TION				
E	Maryland Montgomery		ckville	ATION			10d. INSIDE CIT LIMITS?	
	10e. STREET AND NUMBER			of, ZIP CODE		T 40 - 01711	1 YES 2 ZEN OF WHAT COUNTRY?	NO
FUNERAL	1219 Allison Drive				851		ed States	
N.	11. MARITAL STATUS 12. WAS DECEDENT EVER IN	N U.S. ARMED	13 WAS DE		NIC ORIGIN? (Specify Yes		14. RACE — American Inc	
I	1 Never Married 2 Married FORCES? 1 YES	2 V NO	If yes, a	pecify Cuban, Mexic	an, Puerto Rican, atc.)	OF NO.	Black, White, atc.	len,
В	3\tag{Y} Wildowed 4 Divorced IF YES, GIVE WAR OR D	A163	1 '''	S 2 NO Speci	ry:		Specify: Whit	e
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S	USUAL OCCUPAT	ION	16b. KIND OF BU	SINESS/IND	USTRY	
9	Elementary/Secondary (0-12) College (1-4 or 5+)	IIIa. Do NOT us	e retired.)					- 3
MP		School B	<u>us Driv</u>	er	Public	Scho	ools	
8	17. FATHER'S NAME (First, Middle, Last)				AME (First, Middle, Malden	Surname)		
BE	Manuel Perry				Villineau			
2	190. INFORMANT'S NAME (Type/Print) Grant B. Perry				Route Number, City or Tow			
.					ockville, N			
		netary, cramatory or of a y tonsvi	propriese)	fame of			City or Town, State	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEF	aytonsvi	lle Cem	etery ND ADDRESS OF FA	2/1 Layt	onsvi	ille.Maryla	nd
	NO 0		Muri	el H. Bai	rber Funera	1 Hon	ne 20882	
	May Warley		2152	5 Laytons	sville Road	Lavi	consville	Md.
	23. PART I. Entar the diseases, or complications that caused shock, or fleart failure. List only one cause on e	d the death. Do n	ot enter the m	oda of dying, suc	ch ss cardisc or resp	ratory arre	est, Approxin	nate
	IMMEDIATE CAUSE (Final						Onset sn	
	resulting in death) a. DUE TO (OR AS A	onia					2wa	Es
	DUE TO (OR AS A	CONSEQUENCE OF	7:) .				
		Sequentially list conditions. To Chromic Obstructive Pulminony Disease 10 years						- 1
NO		Obstruct of	Rue +	4/wonony	Disea	se	10 4	cors
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	O 65 Truc	Rue +	4/wonony	Disea	se	10 4	eors
FICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	O 6 5 True CONSEQUENCE OF): 	er/wonony	Disea	se	10 4	eors
RTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	CONSEQUENCE OF): 	"Ind non	Disea	æ	10 4	eors
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	CONSEQUENCE OF):				10 4	cors
	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death b	A CONSEQUENCE OF):): n the undarivir	Q Cause given in	Part I. 24e WAS AN	AUTOPSY	24b. WERE AUTOPSY I	TO
DICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death b	A CONSEQUENCE OF):): n the undarivir	Q Cause given in	Part I. 24e WAS AN	AUTOPSY MED?		TO
MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death be a contributing to death be caused to the feather with the conditions contributing to death be a contributing to death be caused to the feather with the conditions contributing to death be a conditions contributing to death be a conditions contributing to death be a conditions contributing to death be a conditions contributing to death be a conditions contributing to death be a conditions contributing to death be a conditions contributing to death be a conditions contributing to death be a conditions contributing to death be a conditions contributing to death be a conditions contributing to death be a conditions contributing to death be a conditions contributing to death be a conditions contributing to death be a conditions contributing to death be a condition of conditions contributing to death be a condition of conditions contributing to death be a condition of conditions contributing to death be a condition of conditions contributing to death be a condition of conditions contributing to death be a condition of conditions contributing to death be a condition of conditions conditio	a consequence of	n the undarlyin	g cause given in	Part I. 24e. WAS AN PERFOR	AUTOPSY MED?	AWAILABLE PRIOR COMPLETION OF	TO CAUSE
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MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death b Dicklefe Melling Cong. DID TOBACCO USE CONTRIBUTE TO CAUSE O 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OF DEATH YE	n the undarlyin Cert S NO [H (Check only one	g cause given in	Part I. 24e. WAS AN PERFOR	AUTOPSY MED?	AVAILABLE PRIOF COMPLETION OF OF DEATH?	TO CAUSE
MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death be a contribution to death be a contributing to death be a contribution to death be a contribution to death be a contribution to dea	CONSEQUENCE OF	n the undarlyir S NO [H (Check only one OTHER: 4 Nursing Hot	g cause given in Four we UNCERTAI	Part I. 24e. WAS AN PERFOR 1 U YES 2	AUTOPSY MED? ODHO	AWAILABLE PRIOR COMPLETION OF OF DEATH? 1 YES 2	TO CAUSE
PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death b Diction for Medical DID TOBACCO USE CONTRIBUTE TO CAUSE O 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 28. DATE OF INJURY (Month Day Year) 1 Yes 2 Yes 1	OF DEATH YE	n the undarlyir S NO L K (Check only one OTHER: 4 Nursing Hot E OF 28c. IN WHY 28c. N	UNCERTAI	Part I. 24e. WAS AN PERFOR	AUTOPSY MED? ODHO	AWAILABLE PRIOR COMPLETION OF OF DEATH? 1 YES 2	TO CAUSE
BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death be a condition of the condition of the	OF DEATH YE 26. PLACE OF DEAT 28b. TIME	n the undarlyin S NO E H (Check only one OTHER: 4 Nursing Hote WHY M 1	UNCERTAI	Part I. 24a. WAS AN PERFOR 1 YES 2 N	AUTOPSY MED? DONO	AWAILABLE PRIOR COMPLETION OF OF DEATHY 1 YES 2 URED	TO CAUSE
BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death b Di che for Mc (Uhu Chro) DID TOBACCO USE CONTRIBUTE TO CAUSE O 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 DINO 1 Pinpettent 2 ER/Outp 27. MANNER OF DEATH 1 Notural 5 Pending	OF DEATH YE 28. PLACE OF DEAT PATHORN, Farm, s	n the undarlyin S NO E H (Check only one OTHER: 4 Nursing Hote WHY M 1	UNCERTAI	Part I. 24e. WAS AN PERFOR 1 U YES 2	AUTOPSY MED? DONO	AWAILABLE PRIOR COMPLETION OF OF DEATHY 1 YES 2 URED	TO CAUSE
BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant conditions contributing to death b Cube for Mc (Ube Characteristics) Characteristics	OF DEATH YE 26. PLACE OF DEAT Petient 3 DOA 28b. TIME INJ	n the undarlyin S NO L H (Check only one OTHER: 4 \(\) Nursing Hot E OF WM 1 \(\) treet, factory, offi	UNCERTAI DIANT AT ORK? YES 2 NO	Part I. 24e. WAS AN PERFOR 1 VES 2 N S Other (Specify) 28d. DESCRIBE HOW II 28f. LOCATION (Street City or Town, State)	AUTOPSY MED? DONO NJURY OCC	AWAILABLE PRIOR COMPLETION OF OF DEATH? 1 YES 2 URED OF Rural Route Number,	TO CAUSE
BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant conditions contributing to death by the conditions co	OCONSEQUENCE OF CONSEQUENCE OF CONSEQUENCE OF CONSEQUENCE OF CONSEQUENCE OF DEATH YE 26. PLACE OF DEAT CONSEQUENCE OF DEATH YE 28b. TIME INJURY At home, farm, s	n the undarlyin Cont H (Check only one OTHER: 4 Nursing Hot E OF 26c. IN WITH 1 1 treet, factory, offi	UNCERTAI UNCERTAI DIA TORK? YES 2 NO	Part I. 24e. WAS AN PERFOR 1 VES 2 N S Other (Specify) 28d. DESCRIBE HOW Is City or Town, State)	AUTOPSY MED? DONO NJURY OCC and Number of	AWAILABLE PRIOR COMPLETION OF OF DEATHY 1 YES 2 URED Or Rural Route Number,	TO CAUSE
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the huriar transit	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPI	TO THE FUNER	be filed within	IMPORTANT

	FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPAR	TMENT OF	HEALTH AND	MENTA	AL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)						E OF DEATN		3	. TIME OF DEAT	Н
	Fay Theresa Point	t-Sudduth				Jar		6, 199	PAR 95	10:00	Рм
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (II	in yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	0.	BIRTNPL	LACE (State or For	-
			3 YRS.	MONTHS DAYS	HOURS MIN.	Jur	ne 30,1		Vash:	ington,	DC
10	9a. FACILITY NAME (If not institution, give street	t and number)		9b. CITY, TOWN	OR LOCATION OF D			9c. COUNTY			
\e	9510 Hale Place			Silve	r Spring			Mont	gom	ery	
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		I the CIT	Y, TOWN OR LOC	ITION				14	Od. INSIDE CITY	
H	Maryland Montgon	ne r v		lver Sp					- 1	LIMITS?	
9	10e. STREET AND NUMBER	ic Ly	1 31		M. ZIP CODE			10a CITIZEI		X YES 2	NO
FUNERAL DIRECTOR	9510 Hale Place				20910					States	
5		2. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DE	CENDENT OF NISPA	NIC ORIGI	N? (Specify Yes			- American India	n.
BY F	1 Never Married 2 Merried	FORCES? 1 YES	2 NO	If yes, s	pecify Cuben, Mexico	en, Puerto	Rican, etc.)	41.75	Black, V Specify:	White, atc.	
	3 Widowed 4 Divorced	100000000000000000000000000000000000000							.,,	Black	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con	TON mpleted)	16a. DECEDENT'S (Give kind of s	USUAL OCCUPAT work done during n se retired.)	ION lost of working	16	b. KIND OF BUS	SINESS/INDUS	TRY		
7	Elementary/Secondary (0-12)	College (1-4 or 5+)					** 0 0				
ME	17. FATNER'S NAME (First, Middle, Last)	2	Executi	ve Secr		_	U.S. G		nent		
	Esaw Point				18. MOTHER'S NA			Surneme)			
BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	end Number or Rural		Swest	n Ctota 7in Co	ofa l		
2	Joe W. Sudduth		1		ace, Silv		-			0_1300	
	METHOD OF DISPOSITION	20b.	PLACE AND DATE	DE DISPOSITION /	lame of		TE 20c. LO				
0	1	I from State Ceme	etery, crematory or o	t Cemete	ery 1	/31/	'95 Was	hingto	n. I	D.C.	
	21. BIGHATUM OF FUNERAL SERVICE LICENS	101-		22. NAME /	ND ADDRESS OF FA	CILITY					
	1 m 1/11	11/90	my	McGu:	ire Funer Georgia	al S	Service	, Inc.		D 0	
	27. PART I. Enter the diseases, or com	nplications that caused	tha death. Do r	not antar tha m	oda of dying, aud	h as car	diac or respi	ratory arreal	ngto	Approxime	
	shock, or heart fellure. List	t only one ceuse on ae	ch line.								
	IMMEDIATE CAUSE (Final	01		,						Interval Be	
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Gliob		4 M	Stita	mo	_			Onaet and	
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Gliob DUE TO (OR AS A		na Mu	Mifa	me	_				
NO	disease or condition resulting in death) e	Gliob DUE TO (OR AS A	laston consequence of		Mifor	me	_				
ATION	disease or condition resulting in death) e Sequentially list conditions, if any, laeding to immediata	Glub-	laston consequence of		eltifor	me	-	_			
FICATION	Sequentially list conditions, if any, leeding to immediata cause. Enter UNDERLYING CAUSE (Disease or injury		CONSEQUENCE OF	F):	Mifor	me					
RTIFICATION	disease or condition resulting in death) Sequentially list conditions, if any, laeding to immediata cause. Enter UNDERLYING	DUE TO (OR AS A DUE TO (OR AS A	CONSEQUENCE OF	F):	Mifor	me					
CERTIFICATION	Sequentially list conditions, if any, laeding to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	F):	0						
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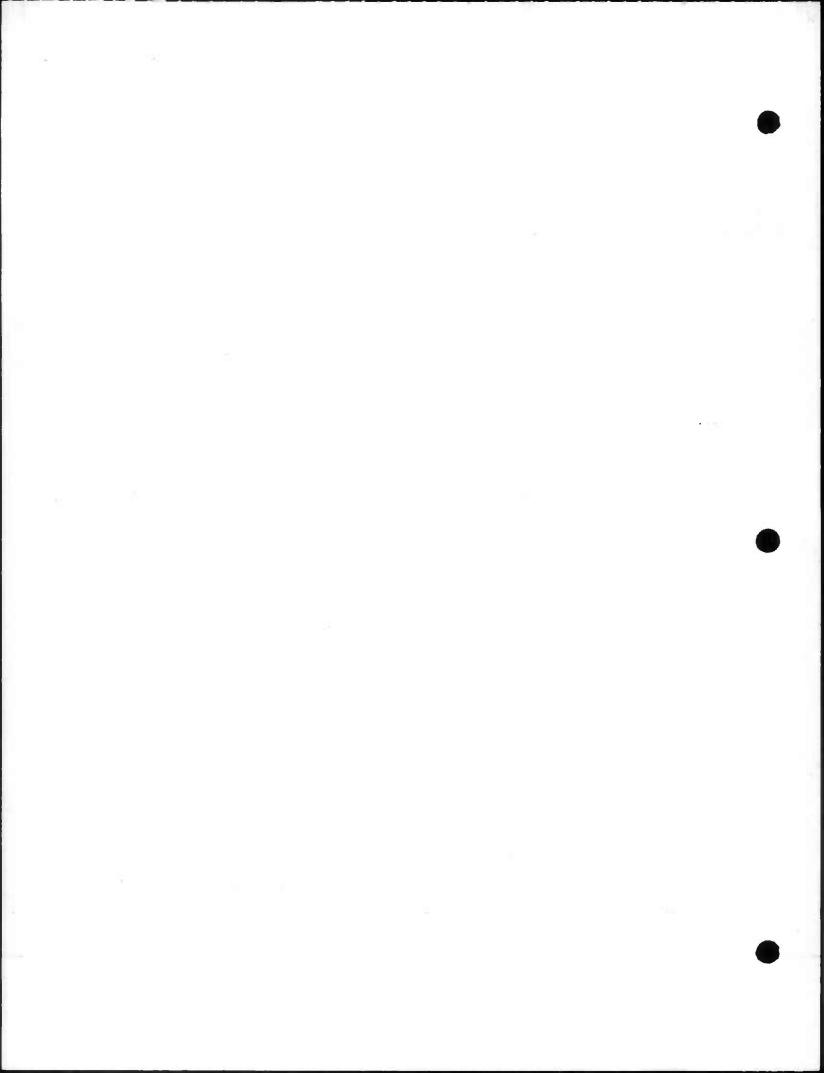
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Z8 2 P VAVID EIKOFF 01 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 1 M 2 D F DAYS HOURS 578-60-8205 YRS. March 21 1900 Russia 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 9268 Cherry Lane Apt. #61 Laure1 Prince Georges 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Md. Montgomery Laurel 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? burial-transit 9268 Cherry Lane Apt. #61 20707 USA 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No-14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married It yes, specify Cuban, Maxican, Puarto Ri 1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES Specify: White BY 3 Widowed 4 Divorced use as the ETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY 10g Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Fundraiser Education funeral director, page 5 should be detached once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) notified at Mendel Peikoff BE Sarah Orloff 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Pauline Peikoff 9268 Cherry Lane Apt.#61 Laurel, Md. 20707 þe 20a. METHOD OF DISPOSITION
1 ☐ Burial 2 ※ Cremetion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 4 Donation 5 Other (Specify) Metropolitan Crematory 1-29-95 Alexandria, Va. the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 20852 ysician and completely filled in by the prior to burial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heert fellure. Liet only one ceuse on each line. Interval Betwe IMMEDIATE CAUSE (Finel Onset and Death disease or condition Canasiourscusz Acciosin within event. reculting in death) DUE TO (OR AS A CONSEQUENCE OF): executed Marins MB4T43 traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate the attending physician Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Diseese Dr Injury or other DUE TO (OR AS A CONSEQUENCE OF): thet initiated evente resulting in death) LAST PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE shows any 1 ☐ YES 2 ☐ NO OF DEATH? 1 TYES 2 NO has been s Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h OTHER: 1 X YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Masidence 8 Other (Specify) 00 27. MANNEB OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending Investigation 1 YES 2 NO ВҰ THE HOSPITAL OR ATTENDING F THE FUNERAL DIRECTOR: After t filed within 72 hours after death 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 COMPLETED 8 Could not be after 1 4 Homicide 28 determined Hem 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) IMPORTANT: If 2 MEDICAL EXAMINER: On the basis of axemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 24886 29/95 D 223 2 SON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sping MUL T_{ν} 9801 GEORGIA 20902 ME SILVER

32. REGISTRAR'S SIGNATURE

1995

Davidson Rend

DHMH-16 Rev 1/89



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v requires that the death certinicate be executed within <- hours after death. Page 6 may be retained by the hospital or arress.	been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the act Health and Mental Avidina paids to binds on semantics or semand	100
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5	Sign	2
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

or attending ph	r use as the bu		
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or amending the	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bar		IMPORTANT: If Item 28 is merked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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Page 6	al direct		ner m
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ATTENC	CTOR:	after o	28 Is
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40SPIT	UNERA	rithin 7.	ANT
THE +	TO THE F	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORT

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31. DATE FILED (Month, Day, Year)

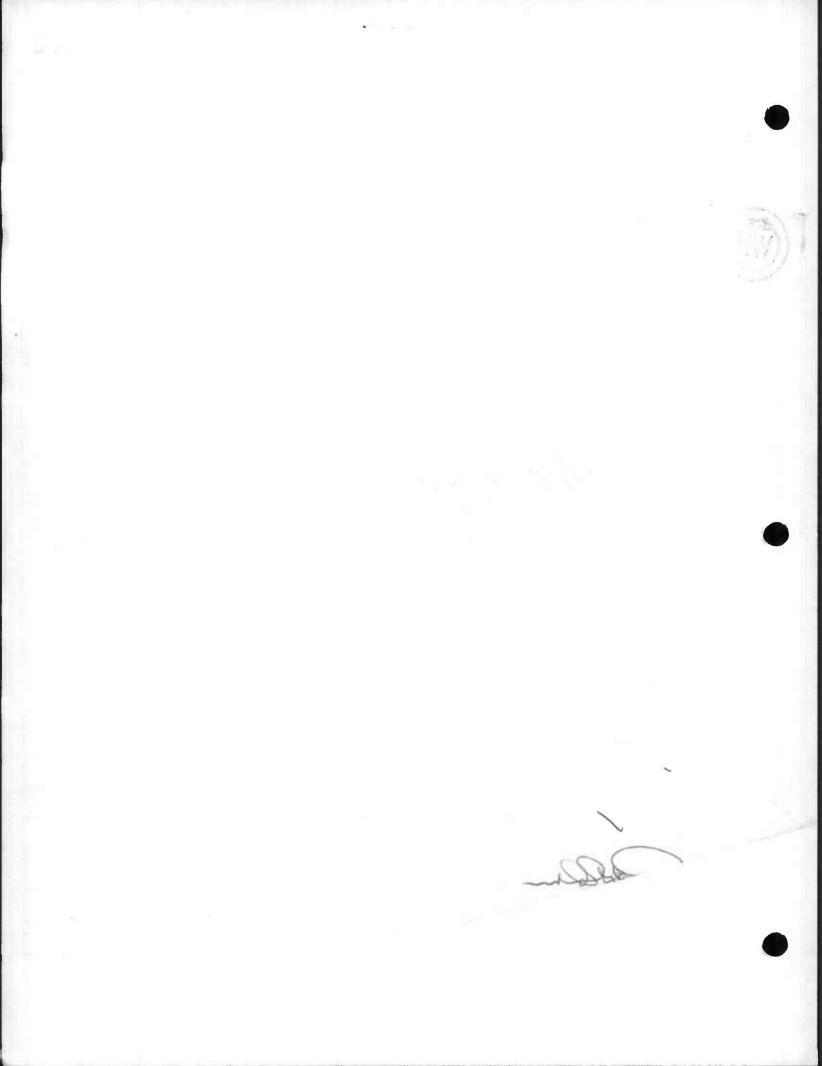
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1 - FOR STATE REGISTRAR		STATE OF			RTMENT O			MENTAL HYGIEN REG. NO.	E		
1. DECEDENT'S NAME (irst, Middle, Last)							2. DATE OF DEATH			3. TIME OF DEATH
Herman Wa	lter Re	ynolds						January 4	, 199	95 ^{EAR}	0820
4. SOCIAL SECURITY N	JMBER	5. SEX	6. AGE (In yrs. In	ast birthday)	IF UNDER 1 Y	EAR IF UN	DER 24 HMS.	7. DATE OF BIRTH		6. BIRT	HPLACE (State or Foreign
215-20-26	73	1 📉 M 2 🗌 F	87	YAS.	MONTHS D	AYS HOUR	MIN.	February 22	. 190	7 Vi	reinia
9e. FACILITY NAME (# #		street and number)			9h CITY TO	WIN OR LOCA	TIDN DE D			NTY OF C	
						heste			sc. 000	Ken	
Magnolia Hall Nursing Center C						Heste	LCOWI			ICII	
10a. STATE	10b. COUNTY	Υ		10c. CIT	Y, TOWN OR I	OCATION					10d, INSIDE CITY
Maryland		Kent			V	orton					LIMITS?
10e. STREET AND NUM	ER					10f. ZIP C	NDE .		40- OIT	TEN OF	WHAT COUNTRY?
24909 Mor	tobollo	Tolso Do				1,50,7 1,000,000			_		
	Laberro						21678				States
1 Never Merried 2 Merried FORCES? 1 YES 2 NO					If ye		ban, Maxica	NIC ORIGIN? (Specify Yes an, Puerto Rican, atc.) ly:	or No—		E — American Indian, ik, Whita, atc. illy: Lte
	DECEDENT'S EDU				USUAL OCCU			16b, KIND OF BUS	INESS/IND		
(Specify Elementary/Seconda	only highest grade	College (1-4 or 5	- 4	(Give kind of the Do NOT u	work done duri se retired.)	ng most of wo	rking				
6	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	courses fred OLD	1	TOP T	rimmer			Landsc	200		
17. FATHER'S NAME (Firs	I, Middle, Last)			LCC I	Timmel		THEB'S P	AME (First, Middle, Maiden			
James W.		s						Mutterspa			
19a. INFORMANT'S NAM								-		_	
Mrs. Audr		_		2/10/10	Monto	bollo	T also	Route Number, City or Town	ton	Mor	wland 2167
							Lake		_		
20g, METHOD OF DISPO		oval from State	20b. PLACI cemetery, c	EAND DATE	OF DISPOSITIO	N (Name of		DATE 20c. LO	CATION —	City or To	own, State
4 Donation 8 0		11	ches	ter C				6, 1995 Ches	terto	wn, l	faryland
21. SIGNATURE OF FUN	HAL SERVICE LIC	799	7//	()		ME AND ADD		ells Funera	1 II.		
► USI	Iliam L.	King Ir	" Acer	1							
			et caused the c	feeth Do r	oot enter the	o mode of	t HIE	h Street,	unes	tert	Approximata
shock, o	r heart failure.	List only one car	use on each lin	ne.	not enter the	inode of	zymig, suc	il as caldiac of respi	atory an	est,	Interval Between
IMMEDIATE CAUSE disease or condition		1	121		0.			(=			Onset and Dea
resulting in death)	\rightarrow	a. /d	1 thm	~~	ou	den	_	(END SO	1068	-)	>5 go
		DUE TO	DR AS A CONS	EDUENCE O	F):						
Sequentially list cor	ditions	b									
If any, leading to Im	mediate	DUE TO	OR AS A CONSI	EQUENCE O	F):						
CAUSE (Disease or		C									
that initiated events resulting in death) L		OUE TO	OR AS A CONSI	EDUENCE O	F):						
resulting in death) L	NSI	d									
PART II. Other eigni	icant condition	as contributing to	death but not	regulting	In the under	rhdna onus	a elsea la	Bert I as uncau	UTDOOU	1 40	
45.0	7	- Contributing to	, dectil but not	readiting	iii tile ulide	riying caus	given in	Part I. 24a. WAS AN . PERFOR		248	AWAILABLE PRIOR TO
- 6.1								1 _ YES 2	□ NO		COMPLETION OF CAUSE OF DEATH?
								_			1 YES 2 NO
25. WAS CASE REFERRE EXAMINER?	TO MEDICAL					26. PLACE OF	DEATH (Ch	eck only one)			
1 TES 2 NO		HOSPITAL:	☐ ER/Outpatient	3 DOA	OTHER:	Home 5 🗆	Rasidence	8 Other (Specify)			
27. MANNER OF DEATH		28a. DATE OF	F INJURY	28b. TIM	E OF 28	c. INJURY AT		28d. DESCRIBE HOW IN	JURY OC	CURED	
	Pending	(Month, E	Day, Year)	IN.	JURY	WORK?	□ ND	ANGELOW TENEDON			
2 Accident 3 Suicide	Investigation	28e, PLACE (OF INJURY At h	nome, farm.				281. LOCATION (Street a	nd Number	or River	Boute Number
4 Homicide	Could not be detarmined	building	, atc. (Specify)					City or Town, State)	Humber	or regret i	round (YUTHOUT,
29a, CERTIFIER											
(Check only								to the cause(a) and man			
2 D	EDICAL EXAMINE	R: On the basis of a	examination and/or	r investigatio	on, in my opini	on, death oc	cured at the	time, data and place, and	due to th	e cause(i	s) and manner as stated.
286. SIGNATURE AND T	LE OF GESTIFUE	A					CENSE NUI		29d. DAT	SIGNED	(Month, Day, Year)
1	Fach	~				1	036	054	P 1	5	95
						1	- C		- 1	1"	

32. REGISTRAR'S SIGNATURE
Julia Davidson-Randelle

21620



20.	nysic .	urial	
BALTIMORE, MARYLAND 21215-0020	ours after death. Page 6 may be retained by the hospital or attending p	I in by the funeral director, page 5 should be detached for use as the bir removal.	nedical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burian has find within 72 having after death with the State Dect of Health and Mental Hobiene order to burial, cremation, or removal.	IMPORTANT: If tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

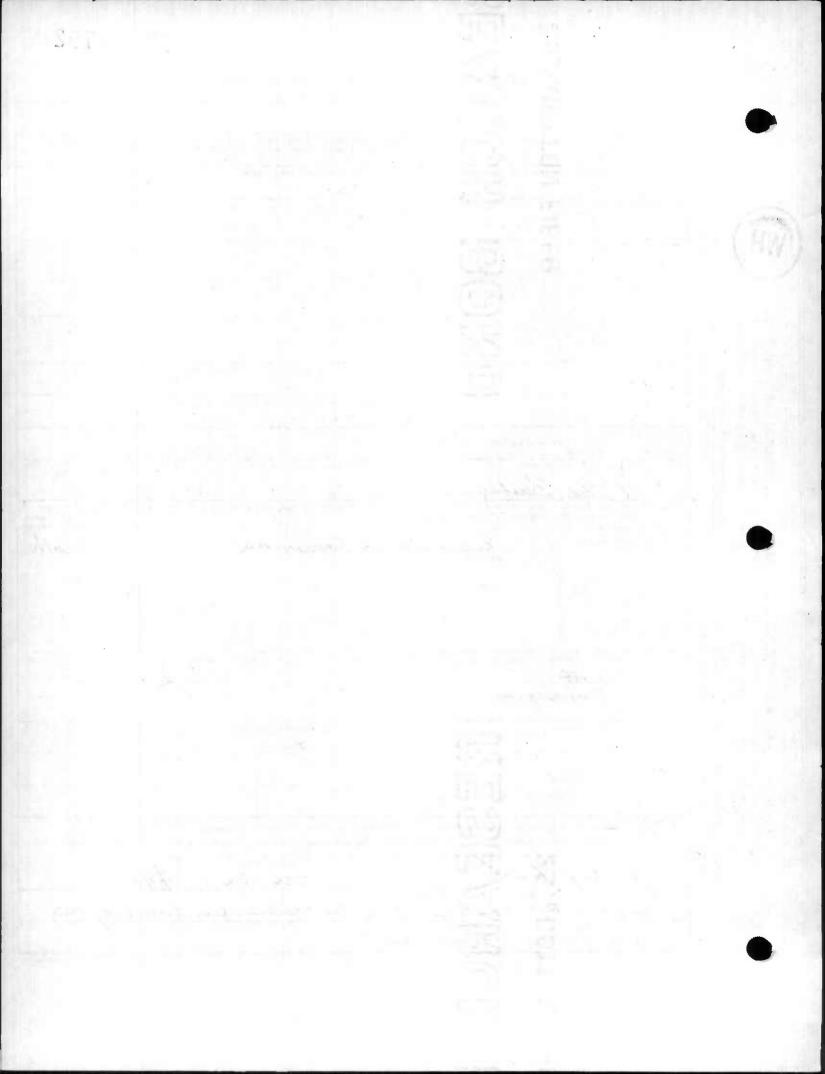
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCIENE

1 - STATE REGISTRAR 1. DECEDENT'S NAME (First	Middle Leet		(F DEATH		REG. NO.			
	EROME	RALEY,	SR.				JAN	ATH DA	199	5 YEAR	5:40 A
4. SOCIAL SECURITY NUMBER 1		5. SEX	6. AGE (In yrs.		IF UNDER 1 YEAR		7. DAT	E OF BIRTH	-	B. BIRTHI Country	PLACE (State or Foreign
577-07-8366		1 🔯 M 2 🗆 F	84	YRS.			DEC	c. 5, 19		D.	
9a. FACILITY NAME (# not in GARRETT COURSEIDENCE OF DEC	NTY ME		OSPITA	L		LAND	DEATH			NTY OF DE	
10a. STATE D. C.	10b. COUNTY	1	10c. CITY, TOWN OR LO WASHING							10d. INSIDE CI LIMITS?	
10e. STREET AND NUMBER						IOI. ZIP CODE			10a. CIT	IZEN OF W	1 X YES 2 NO
6611 5TH S	TREET,	N.W.				20011				USA	
11. MARITAL STATUS 1 Never Married 2 3 Wildowed 4 Dive		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	ARMED X NO	If yes,	ECENDENT OF HISI specify Cuban, Max ES 2 NO Spe	Ican, Puari		or No—	Black,	- American Indian, White, etc.
15. DEC (Specify onl Elementary/Secondary (6)				1	NEWSPA				
17. FATHER'S NAME (First, AMENRY J.	RALE	EY				18. MOTHER'S MARY		t, Middle, Meiden RNSTEIN	Sumame)		
190. INFORMANT'S NAME (I						ALLEY T					96003
20a. METHOD OF DISPOSIT 1 Burial 2 Cremetic 4 Donation 5 Other	n 3 🗆 Rem	oval from Stata			MATORY	Name of		30 MORG		WN, V	
21. SIGNATURE OF FUNERA	SETTINGE LIC	Quest	M00	167		AND ADDRESS OF	.,			BOX 2	
23. PART I. Enter the d ahock, pr h IMMEDIATE CAUSE (Fit disease or condition resulting in death)	eart fellure.	a. LIVER	FAILUF	RE		node of dylng, s	uch es ce	erdisc or respi	ratory er	rrest,	Approximate Interval Betwee Onset and Dec
Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST metastatic carcinoma of the gallbladder Due to (or as a consequence of): Due to (or as a consequence of): d											
PART II. Other significa	nt condition	s contributing to	deeth but no	ot resulting	in the underly	ng ceuse given	in Part I.	24s. WAS AN PERFOR	MED?		WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACC	O USE	CONTRIBUTE	TO CA	USE OF	DEATH	YES N	10 FA				1 1 1 2 1 10
25. WAS CASE REFERRED T EXAMINER?		HOSPITAL:				PLACE OF DEATH		one)			
1 TES 2 NO		1X Inpetient 2		_	4 - Nursing H	ome 5 - Residenc					
	Pending Investigation	28a. DATE OF (Month, De		28b. TIM	URY	NJURY AT YORK? YES 2 NO	28d. D	EŞCRIBE HOW II	NJURY OC	CUREO	
3 Suicida 8	Could not be determined	28s. PLACE Of building,	F INJURY — At atc. (Specify)	home, farm,	street, factory, of	lica		CATION (Street a ty or Town, State)	and Numbe	er or Rurei A	oute Number,
		CIAN: To the best of									and manner as stated.
29b. SIGNATURE AND T	086	laun		_ 1	10.	D25759					(Month, Day, Year) y 29,1995
30. NAME AND ADDRESS OF Walter K. N						t MD 215	520				
31. DATE FILED (Month, Day, FEB - 1	1995	32. REGISTRA	R'S SIGNATURE								

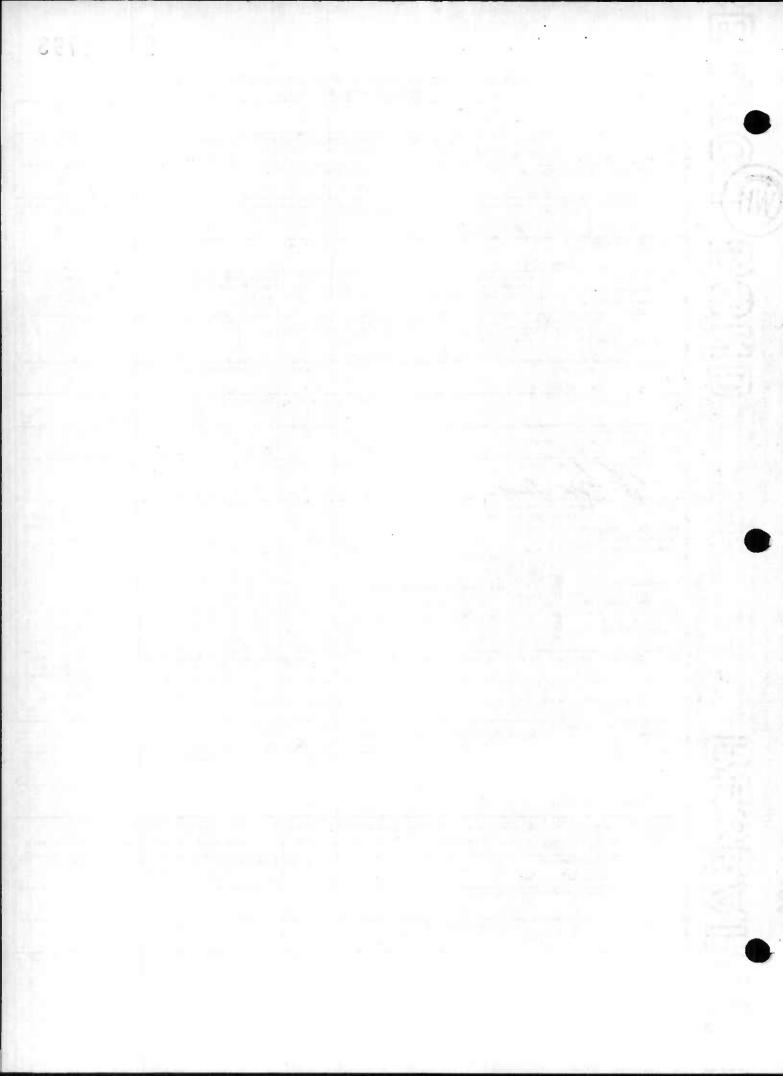
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

						IOAII		DEA		HEG. N	O.		
	1. DECEDENT'S NAME (First, Midd Mildred Lee		hardsor	1						2. DATE OF DEATH MONTH	DAY 2	YEAR 95	1:52 P M
	4. SOCIAL SECURITY NUMBER 212-18-6059		SEX	6. AGE (In yrs. les		IF UNDER	t YEAR	IF UNDER	R 24 HRS.	7. DATE OF BIRTH (Month, Pay, Year)	_		ACE (State or Foreign
				07	YRS.			DAYS HOURS MIN. (Month, Pay, Year) 7 Count					VA
~	9e. FACILITY NAME (If not institution					9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF D							
TOT:	36391 Poplar Neck RD						Villa	illards Wicomico)	
DIRECTOR	MD 100. STATE	co	10c. CI1	WWW.	ards					Dd. INSIDE CITY LIMITS? YES 2 M NO			
FUNERAL	100. STREET AND NUMBER 36391 Poplat		101. ZIP CODE 21874				1 U Y						
BY	ti. MARITAL STATUS t Never Married 2 Marri 3 Widowed 4 Divorced	T EYER IN U.S. AR	MED NO		It yes, sp		ın, Maxica	IIC ORIGIN? (Specify Y n, Puerto Rican, etc.)	es or No—		- American Indian, White, etc. White		
8	15. DECEDEN	T'S EDUCAT	TON		CEDENT'S					16b. KIND OF B	USINESS/IN	DUSTRY	
COMPLETED	(Specify only high Elementary/Secondary (0-12)	1	College (1-4 or 5	iii a	Wait	se retired.)	during m	ost of worki	ng	R	estau	ırant	
O	17. FATHER'S NAME (First, Middle,	Last)						18, MOT	HER'S NAI	ME (First, Middle, Maide	n Surname)		
BEC	Jackson B	untin	ng							Ann Fish	,		
TO B	19a, INFORMANT'S NAME (Type/Pi Shirley Co			19						Poute Number, City or To			74
	20s. METHOD OF DISPOSITION 1 Duriet 2 Cremetion 3			20b, PLACE	AND DATE	OF DISPOS	SITION (N	_				City or Town	
	4 Donation 5 Other (Spec	ify)		Ever		n Ce	emet			2/6/95 Be	erlin,	MD	
	21. SIGNATURE OF FUNERALISES		Bu bas					ND ADDRE		St. Berli	_		Home
	23. PARTY. Enter the disease		ut pu		ath Da								Approximate
CERTIFICATION	shock, or heart failure. List only ope cause on each line. Interval Between Onset and Death Death Onset and Death Death Onset and Death												
	DART II Osbara la Mina	0	- 41 -1										+
MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF									ERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO			
PHYSICIAN:	25 WAS CASE DESERBED TO ME	DICAL T											
Image: Control of the control of the	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:												
. i ≥ i	t YES 2 NO	<u>'</u> '	28s. DATE OF	ER/Outpatient 3	28b. TIR			JURY AT	egidence	6 Other (Specify)		011050	
ВУ Р	1 Natturel 5 Pend 2 Accident Invest	ing Igation	(Month, E		IN	JURY M	W	YES 2 [□ NO	26d. DESCRIBE HOW	INJURY OC	COMED	
0	3 Suicide 6 Coule	I not be	28s. PLACE C building,	of INJURY — At ho	me, tarm,	street, fac	tory, offic	0		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLET										to the cause(s) and m			
8				Administration and/or	- Industry		opinion, i				and dua to t	na cause(a) a	nd manner as stated.
BE	296. SIGNATURE AND TITLE OF C	A Z	if	H					ENSE NUN		29d. DAT	SIGNED (A	fonth, Day, Year)
2	30. NAME AND ADDRESS OF PER	SON WHO C	COMPLETED CAU	SE OF DEATH (ITE	M 27) (Type	, Print)		- V-	3	. 0	177	/	
	RONALD	P.	TRAC	ITZ		60	RI	VER	5100	DR	SHAI	SBUR	MO
2	St. DATE FILED (Morth, Day Year)	1995	32. REGISTRA	AR'S SIGNATURE	اعمايما							1	
						-6:							DHMM-16 Day 1/8



DIVISION OF VITAL RECORDS, P.O. BOX 68760	BALTIMORE, MARYLAND 21215-0020
TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with yours after death. Page 6 may be retained by the hospital or attending physicial	hours after death. Page 6 may be retained by the hospital or attending physici
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-to filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	of in by the funeral director, page 5 should be detached for use as the burial-tor removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	medical examiner must be notified at once.

FOR STATE REGISTRAR	STATE OF MARY		ARTMEN IFICAT				HYGIENE REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF MONTH	DEATH	YEAR	3. TIME OF DEATH
Doris Ione Rey	nolds					2	4	95	11:05 A
4. SOCIAL SECURITY NUMBER		(In yrs. last birtho	MONTHS		IF UNDER 24 HRS.	7. DATE OF (Month, D	BIRTH (ay, Year)	8. BIRT	HPLACE (State or Foreign
579-48-3454 Se. FACILITY NAME (If not institution, give st		86 YR	S.		LOCATION OF I	1/2	9/09		SD
48 Tail of the F				<u>Berlin</u>	LOCATION OF L	JEATH	9c. 0	Worce	
10a. STATE 10b. COUNTY	Worcester	10c.	CITY, TOWN	or Location					10d. INSIDE CITY LIMITS?
10a STREET AND NUMBER	Worcester				II CODE		l ma	OUTSTELL OF	1 ☐ YES 2 1 NO WHAT COUNTRY?
48 Tail of the	Fox			101. 2	21811		log.	CITIZEN OF	USA
11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 NO	13.	If yee, spec		en, Puerto Ric	Specify Yes or No an, atc.)	Blee	CE - American Indian, ck, White, etc.
15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDEN	IT'S USUAL Of of work done		of working	16b. K	IND OF BUSINESS	/INDUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5 +)	Ilfe. Do NO	or use retired.) eache)			Educati	iom	
17. FATHER'S NAME (First, Middle, Lest)	-	1	Gacrie		16. MOTHER'S N	AME (First Mid	dle. Maiden Surnan		
Walter D. Daws	on					a Peck		~/	
19e. INFORMANT'S NAME (Type/Print)		19b. MAII	ING ADDRES	SS (Street and			City or Town, State	, Zip Code)	
Kay Reynolds		23	00 Pin	nmit I	Dr. Ap	t. 617	Falls C	hurc	h, VA 220
20a. METHOD OF DISPOSITION 1 NBurlal 2 Cremation 3 Remo	mal from State	D. PLACE AND DA	TE OF DISPO	SITION /Nam	ent 2	18/05	20c. LOCATION	- City or T	own State
4 Donation 6 Other (Specify)	S	t. Paul	s Epis	scopal	Chur	chyard	Berl	in, M	D
21. SIGNATURE OF TUDERAL SERVICE LIC	Surtas.		22		William	Βι	ırbage I Berlin,		al Home 21811
iMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR AS	A CONSEQUENC	E OF):	7	netast		and a	()	Onset and De
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events		A CONSEQUENCE							
resulting in deeth) LAST	1							-	
PART II. Other aignificant condition	a contributing to deeth	but not resulti	ng in the u	inderlying	ceuse given l		PERFORMED?		b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL				26. PLA	CE OF DEATH (C	heck only one)			
EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Ou	itpatient 3 🗆 DO	OTHE	R:	5 Residence		Specify)		
27. MANNER OF DEATH 1 Natural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b.	TIME OF INJURY M	26c. INJUI WORK	RY AT		RIBE HOW INJURY	OCCURED	
Accident Suicide Homicide	26e. PLACE OF INJUR building, etc. (Sp	RY — At home, fe	rm, atreet, fee	ctory, office		261, LOCATI City or	ON (Street and Nui Town, State)	mber or Rural	Route Number,
anal	CIAN: To the best of my kno								(s) and manner se stated
296. SIGNATURE AND TITLE OF CERTIFIER	ED				D 2 GG			DATE SIGNE	D (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WH				Spaz	40218	<i>د</i> ،			
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG		•						

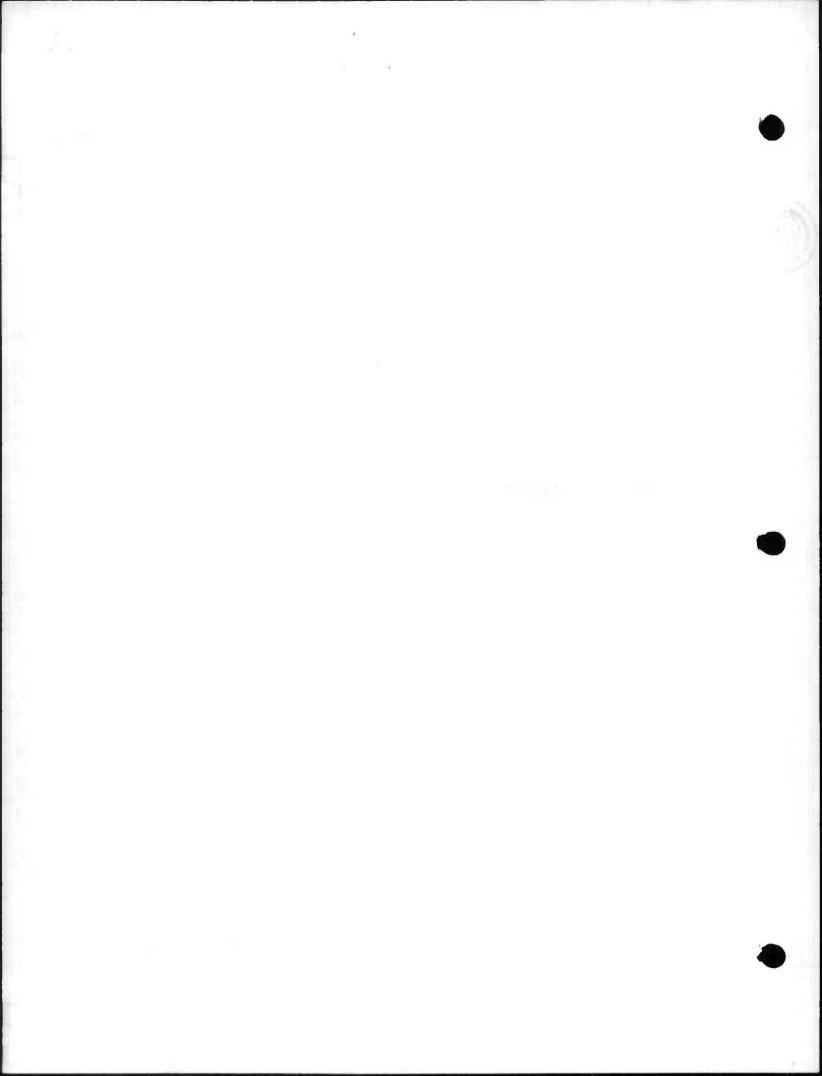


BALTIMORE, MARYLAND 21215-0020	after death. Page 6 may be retained by the hospital or attending physicia	by the funeral director, page 5 should be detached for use as the burlat-tr	icel examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Curs after death. Page 6 may be retained by the hospital or attending physicia	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-to-be filled within 72 hours after death with the State Dest. of Health and Mental Miglere prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is merked, or Item 23 shows eny injury, or other traumatic event, the medicel examiner must be notified at once.

31. DATE FILED (Month, Day, Year) FEB 0 3 1995

32. REGISTRAR'S GIGNATURE
July William Randall

	1. DECEDENT'S NAME (First, Middle, L	1 h.d	RY MARGA		RENNE			2. DATE OF DEATH		YEAR	3. TIME OF DEATH							
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les		IF UNDER 1	ween I we	LINDER 24 HRS	7. DATE OF BIRTH		795	TPM							
	220-09-5772	1 M 2 N F	8.4	YRS.	-		URS MIN.	(Month, Day, Yea)	Countr								
	9a. FACILITY NAME (If not institution, g	- 44	04	Tha.				Oct 18,			souri							
O.B.	Charles County		me							erles								
DIRECTOR	10e. STATE 10b. CO			10c. CIT	Y, TOWN OR	LOCATION					10d, INSIDE CITY							
	Maryland Cha	rles		V	Valdor	cf					1 YES 2 X NO							
A	10e. STREET AND NUMBER					10f. ZIP	CODE		10g. CF	IZEN OF V	VHAT COUNTRY?							
H	3810 Renner Roa	ıd				20	0602			USA								
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	1 Never Married 2 Married FORCES? 1 YES				yes, specify	ENT OF HISPAI Cuben, Mexica ENO Specif	NIC ORIGIN? (Specify an, Puerto Rican, etc. y:	Yes or No-	14. RACI Black Speci Whi	*							
ED	15. DECEDENT'S	18a DE	CEDENTIS	USUAL OCC	HOLTION		THE KIND OF	BUSINESS/IN		LE								
E	(Specify only highest g	rade completed)	(Gi	ive kind of a	work done du	ring most of	working	IOD. KIND OF	BOSINESS/IN	DUSTRI								
1 2	Elementary/Secondary (0-12)	College (1-4 or 5 +	.)		sewife				wn Hor	ne								
COMPLET	17. FATHER'S NAME (First, Middle, Last, Joseph Leo Grus					-16.		AME (First, Middle, Me edwig For	den Sumame)									
BE	19a. INFORMANT'S NAME (Type/Print)		198	. MAILING	ADDRESS (Street and No	umber or Rural	Route Number, City or	Town, State, Zi	o Code)								
2	Helen Miller																	
9	Helen Miller 3830 Renner Road, Waldorf, MD 20602 208. METHOD OF DISPOSITION DATE 206. LOCATION — City of Town, State																	
	1) Burial 2 Cremation 3 1	tion 3 Removal from State cametery, crematory or other place)								wii, Juite								
	St. Peter's Cemetery 2-6 Waldorf, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY																	
	Benjamin Ma	tthews MO	0658				neral		MD 3	20604								
	Benjämin Matthews M00658 P. O. Box 156, Waldorf, MD 20604 23. PART I. Enter the diseasea, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, interval Between the control of the control																	
	ahock, or heart fail.	ire. List only one cau	se on each line								Interval Between Onset and Death							
	disease or condition	G)	Caleur	nh.	The	61					Onest and Death							
1 1	resulting in death)	a. DUF TO	(OR AS A CONSEC															
		552.10	(on no n oonote	OCINOL O	. ,.													
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	b. DUE TO	(OR AS A CONSEC	DUENCE OF	F):													
Y.	cause. Enter UNDERLYING																	
E	CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CONSEC	DUENCE O	F):													
눈	resulting in death) LAST																	
100		0.																
O	PART ii. Other significant condi	tions contributing to	death but not n	eauiting	in the und	eriying car	use given in		AN AUTOPSY	24b	WERE AUTOPSY FINDINGS							
									S 2 NO	- 1	COMPLETION OF CAUSE OF DEATH?							
										ŀ	1 YES 2 NO							
MEDICAL																		
MEDICAL	25. WAS CASE REFERRED TO MEDICA	L I				26. PLACE	OF DEATH (C)	neck only one)										
MEDICAL	EXAMINER?	HOSPITAL:	500 500		отнея:		OF DEATH (CA											
MEDICAL	EXAMINER? 1 YES 2 NO	HOSPITAL:			4 - Nursir	ng Home 5	Residence	6 Other (Specify)	WAY IN HIRDY CO.	Cliner								
PHYSICIAN: MEDICAL	EXAMINER?	HOSPITAL:	INJURY	28b. TIM	4 - Nursir	ng Home 5	☐ Residence		W INJURY OO	CCURED								
MEDICAL	EXAMINER? 1	HOSPITAL: 1 Inpetient 2 Inpetient 2 Month, De	INJURY ay, Year)	28b. TIM INJ	4 Nursir	Bc. INJURY WORK?	☐ Residence	6 Other (Specify) 28d. DESCRIBE HO										
D BY PHYSICIAN: MEDICAL	EXAMINER? 1	HOSPITAL: 1 Inpetient 2 28a. DATE OF (Month, Delian) 28b. PLACE Of building,	INJURY	28b. TIM INJ	4 Nursir	Bc. INJURY WORK?	☐ Residence	6 Other (Specify)	eet and Numbe		Route Number,							
D BY PHYSICIAN: MEDICAL	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident investigat 3 Suicide 6 Could not 4 Homicide	HOSPITAL: 1 Inpetient 2 28a. DATE OF (Month, Delian) 28b. PLACE Of building,	INJURY ay, Year) F INJURY — At ho	28b. TIM INJ	4 Nursir	Bc. INJURY WORK?	☐ Residence	6 Other (Specify) 28d. DESCRIBE HO 28f. LOCATION (Sit	eet and Numbe		Route Number,							
D BY PHYSICIAN: MEDICAL	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident 3 Sulcide 6 Could not 4 Homicide 6 Could not determine 29a. CERTIFIER (Check only) 1 CERTIFYING P	HOSPITAL: 1 Inpetient 2 28a. DATE OF (Month, Delian) 28b. PLACE Of building,	INJURY ay, Year) F INJURY — At horetc. (Specify)	28b. TIM INJ me, farm, :	4 Nursir	ng Home 5 86c. INJURY WORK? 1 YES	Residence	6 Other (Specify) 28d. DESCRIBE HO 28f. LOCATION (Sin City or Town, S	eet and Numbe tate)	or or Rumai i	Route Number,							
D BY PHYSICIAN: MEDICAL	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Neturel 5 Pending Investiget 2 Accident Investiget 3 Sulcide 6 Could not determine 29a. CERTIFIER (Check only 1 CERTIFYING P.	HOSPITAL: 1 Inputent 2 2 28a. DATE OF (Month, De be de be de be de be de la contraction)	INJURY ey, Year) F INJURY — At hosetc. (Specify) my knowledge, de-	28b. TiM INJ me, farm, s	4 Nursir	ng Home 5 8c. INJURY WORK? 1 YES 1, office	Residence AT 2 NO	5 Other (Specify) 28d. DESCRIBE NO 28f. LOCATION (Sin City or Town, S	net and Numberstel)	or or Rural I								
COMPLETED BY PHYSICIAN: MEDICAL	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Neturel 5 Pending Investiget 2 Accident Investiget 3 Sulcide 6 Could not determine 29a. CERTIFIER (Check only 1 CERTIFYING P.	HOSPITAL: 1 Inpetient 2 Inpeti	INJURY ey, Year) F INJURY — At hosetc. (Specify) my knowledge, de-	28b. TiM INJ me, farm, s	4 Nursir	ng Home 5 Bc. INJURY WORK? 1 YES y, office ne, date and inion, death	Residence AT 2 NO	Other (Specify) 28d. DESCRIBE HO 28f. LOCATION (Sin City or Yown, Sin to the cause(s) and titme, date and place.	menner as sto o, and due to t	or or Rural I	s) and manner as stated.							
D BY PHYSICIAN: MEDICAL	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending investigati 2 Accident 3 Sulcide 5 Could not determine 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER?	HOSPITAL: 1 Inpetient 2 Inpeti	INJURY ey, Year) F INJURY — At hosetc. (Specify) my knowledge, de-	28b. TiM INJ me, farm, s	4 Nursir	ng Home 5 Bc. INJURY WORK? 1 YES y, office ne, date and inion, death	Residence AT 2 NO place, and due	Other (Specify) 28d. DESCRIBE HO 28f. LOCATION (Sin City or Yown, Sin to the cause(s) and titme, date and place.	menner as sto o, and due to t	or or Rural I								



1	-	FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICHE

	1 - STATE REGISTRAR			FDEATH		G. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DE	ATH		3. TIME OF DEATH
	DAVLD ALAN RUST				Serves	4 25	1495	12 300 M
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In	yrs. last birthday)	IF UNDER 1 YEAR		7. DATE OF BI	RTH		HPLACE (State or Foreign
	218-78-3270 ¹₺ м ² □ ғ 32	YRS.	MONTHS DAYS	HOURS MIN.	Oct. 12		Coun	m Maryland
	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN	OR LOCATION OF D			OUNTY OF I	
DIRECTOR	405 Barnsby Court			Edgewoo	od		Harf	ord
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	10c CIT	Y, TOWN OR LOC	ATION				10d. INSIDE CITY
E I	Maryland Harford	100.011	.,		7			LIMITS?
1	100. STREET AND NUMBER			EQQE Of. ZIP CODE	ewood	100	OUTSTEN OF	1 TES 2 NO
FUNERAL	405 Barnsby Court				•	10g.		
3	11. MARITAL STATUS 12. WAS DECEDENT EVER IN	U.S. ARMED	13 W4S D	21040 ECENDENT OF NISPA		olfu Van as Na		ISA
BY FL	1 Never Merried 2 Merried FORCES? 1 YES 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATE	2 NO	If yes,	specify Cuban, Mexic	an, Puerio Rican,	etc.)	Blac	E — American Indian, ik, White, etc.
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	18a. DECEDENT'S	vork done durina r	TION post of working	16b, KIND	OF BUSINESS	INDUSTRY	
<u>E</u>	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT us	e retired.)					
N.	17. FATNER'S NAME (First, Middle, Last)	G	rass Cu			Lands		
	Robert Dale Rust, Sr.			200	AME (First, Middle, Pauline		,	
BE	19a. INFORMANT'S NAME (Type/Print)	195 MAILING	ADODESS /Street	and Number or Rural				
2	Ruth P. Rust			Court, Ed				21040
	20a. METNOD OF DISPOSITION 20b.1	PLACE AND DATE	E DISPOSITION /	Nama of	DATE	200 LOCATION	City or T	tuna State
	1 K Buriel 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify)	I Air M	emorial	Gardens	1/28/95	BelA	ir. M	đ.
	21. SIGNATURE OF TUNERAL SERVICE LICENSEE		22. NAME	AND ADDRESS OF F	ACILITY			
!	Stephy a Much			d K. McCo Cokesbury				
	23. PART I. Enter the diseases, or complications that caused	tha daath. Do r	ot anter tha m	ode of dyling, suc	ch as cardiac o	r raspiratory	srreat,	Approximata
	shock, or heart failure. List only one cause on ear	ch iina.		W VANC.		A-LONG-MAIL		Intarval Between Onsat and Death
		- 11-00	ND ON	E HEA	D			Olisar sila besar
	reaulting in dasth) a. SVN SH07 DUE TO (OR AS A C	CONSEQUENCE OF	7):	(/ //				
Z	b							
Ĕ	Sequentially list conditions, If any, leading to immediate	CONSEQUENCE OF):					
2	cause. Entar UNDERLYING CAUSE (Disease or Injury	20110501151105						
	that initiated aventa DUE TO (OR AS A (CONSEQUENCE OF	7):					
CERTIFICATION	d							
AL	PART II. Other algnificant conditions contributing to death but	t not resulting i	n tha underlyl	ng cause given in	Part I. 24a.	MAS AN AUTOP:	SY 241	. WERE AUTOPSY FINDINGS
DICAL						YES 2 NO		AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?
ME						X.		1 TES 2 THO
PHYSICIAN: ME	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	DEATH YE	S I NO I	UNCERTAI	N 🗆			7
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	8. PLACE OF DEAT		9)				
YSI	1 YES 2 NO 1 Inpatient 2 ER/Outpar	tient 3 🗆 DOA	OTHER:	me 5 Residence	6 - Other (Spec	elfy)		
H	27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year)	28b. TIM		JURY AT	28d. DESCRIBE	NOW INJURY	OCCURED	
BY	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation	5 104	£	YES 2 NO	thats	Uf in	he	id.
	3 Suicide 8 Could not be building, etc. (Specific determined	- At home, farm, a	treet, fectory, off	Ice	281. LOCATION City or Town	r, State)	nber or Rural	EDGF WOOD
E					400 Ba	exesty	ict.	MARYLAND 210.
COMPLETED	29a. CERTIFIER (Check only one) CERTIFYING PNYSICIAN: To the best of my knowle							
Š	MEDICAL EXAMINER: On the basis of examination	end/or investigatio	n, in my opinion,	death occursed at the	time, date and p	lecs, and due t	o the cause(s) end manner as stated,
BE	296. SIGNATURE AND TITLE OF CERTIFIER DELLY ME	DICAL E	: KAYNE	29c. LICENSE NU	MBER	29d. [DATE SIGNED	(Month, Day, Year)
10 8	Keiherd Gelfer MD HA	RAMED C	OUNTY	OCA	E	1	lanus	425,1995
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEAT RICHARD J., COLFER, M.D.	TN (ITEM 27) (Type,	Print) 7X	ENPPE C	HURCH	ROAS	20	
	31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S, SIGNA	TUBE	DARLI	NGTON,	MARYL	112	2103	4
	THE COST (MONTH, Day, 10m)	Rardall						

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DNMH-18 Rev 1/89

use as the

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BE

notified at

pe must medical examiner ŏ the cremation, traumatic event, bunal, prior to or other shows any 23 0 marked, death death

CERTIFICATION

PHYSICIAN: MEDICAL

BY

COMPLETED

BE

2

60

Rem

DIRECTOR: hours after of 28

TO THE HOSPITAL
TO THE FUNERAL I
BE filed within 72 h
IMPORTANT: If II

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) RICHAR & S HELEN MAE 5. SEX

2. DATE OF DEATH 7 DATE OF BIRTH

3. TIME OF DEATH 2.36 A M 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign Country) 79 DAYS HOURS MIN. 1 M 2XXX YRS. 176-10-7217 MARCH 1,1915 PENNSYLVANIA 9a. FACILITY NAME (If not institution, give street and number 96. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR CARROLL COUNTY GENERAL HOSPITAL CARROLL WESTMINSTER RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY CARROLL WESTMINSTER maryland 1X YES 2 □ NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 308 BISHOP COURT 21157 USA. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed WDVDIvorced Specify: WHITE 18a, DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) COMPLET Elementary/Secondary (0-12) College (1-4 or 5 +) HOUSEWIFE HOME MAKING 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Sumame) **GEORGE** SIMPSON MAE McDONALD 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 308 BISHOP CT., WESTMINSTER, MD. 21157 BEVERLY CLELLAND 20a. METHOD OF DISPOSITION
tX☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE CADILLAC MEM. GARDENS 1/11 WESTLAND, MICHIGAN 4 - Donation 5 - Other (So HATURE OF THERE S 22. NAME AND ADDRESS OF FACILITY FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23. PART I. Enter the die esses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, heart failure List pnly pne cauea pn each lina. shock, or Interval Between IMMEDIATE CAUSE (Figal Onset and Death disease or condition Alege resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Heunstin Sequentielly liet conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate cause. Enter UNDERLYING disease CONOTES arten DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or injury thet initieted events resulting in deeth) LAST PART II. Other significent conditione contributing to deeth but not reculting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 YES 2 NO 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED DO MEDICAL 28. PLACE OF DEATH (Check only one) OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending М 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, term, streat, tectory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide determined 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

> 60. SEN-Canno

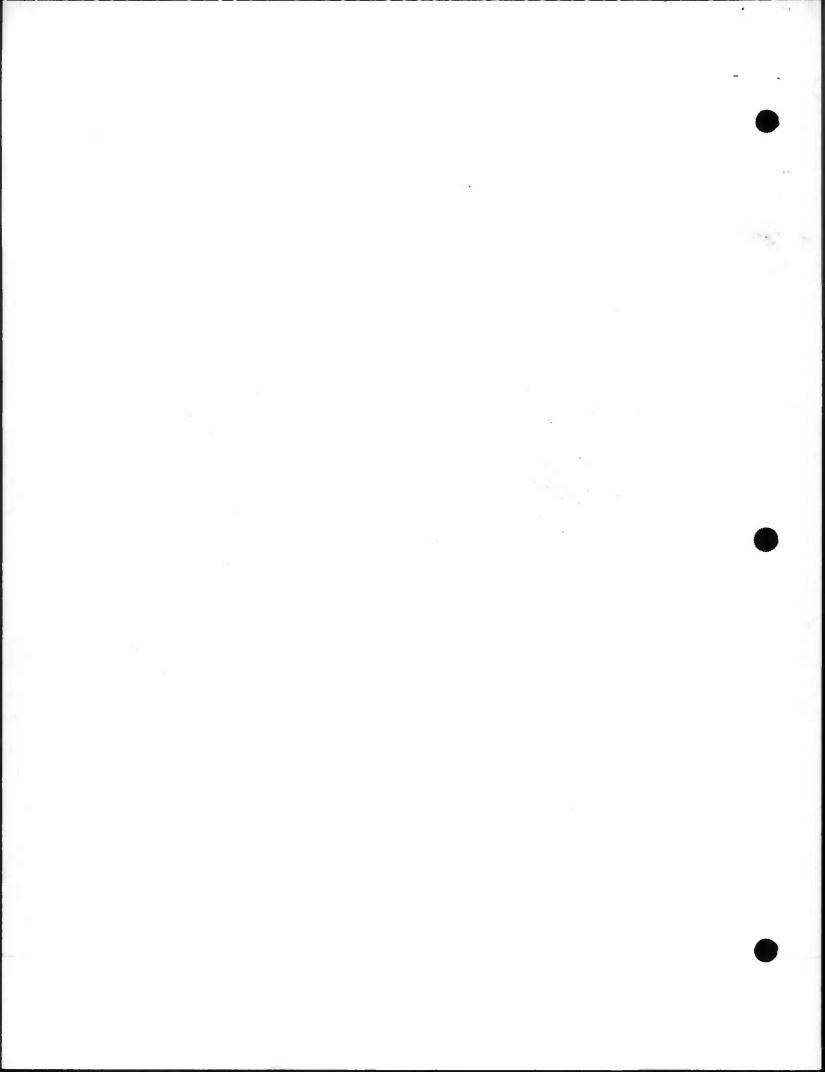
31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Baudson Rada

AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

190 S ATA

Noles

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1 - STATE REGISTRAR			MARYLAN	CERTIF		FOF		н		REG. NO.			
1. DECEDENT'S NAME (First,	Middle, Last)			OLITINI.	O/AII E	- 01	DEAT		2. DATE	OF DEATH			3. TIME OF DEATH
		Lucil	le L	acianne	REY	NOLD	S		Feh	ruary		YEAR QQ5	9:50 A. M
4. SOCIAL SECURITY NUMBER	ER 5.	SEX	a. AGE (In y	rs. last birthday)	IF UNDER		IF UNDER 2		7. DATE	OF BIRTH	7 1	8. BIRTI	HPLACE (State or Foreign
215–18–6819	1	☐ M 2 X F	73	YRS.	MONTHS	DAYR	HOURE	MIN.	July	1, 19	21	Mar	yland
9a. FACILITY NAME (II not ins					9b. CITY	, TOWN O	R LOCATION	N OF DE	ATH		9c. COUI	NTY OF D	DEATH
Frederick		al Hosp	ital		1	Fred	erick				Fı	rede:	rick
RESIDENCE OF DEC	10b. COUNTY			10c. CITY	r. TOWN C	OR LOCAT	ION						10d, INSIDE CITY
Maryland	Frede	erick		1	rede	eric	k						LIMITS?
10e. STREET AND NUMBER						101.	ZIP CODE				10g. CITI	ZEN OF	WHAT COUNTRY?
511 Lee F							217	02			Ţ	J.S.	Α.
11. MARITAL STATUS 1 Never Merried 2 X I		FORCES? 1	T EVER IN U.S	S, ARMED	13.	WAS DECI	ENDENT OF	HISPANI	C ORIGIN	l? (Specify Yee	or No-	14. RACI Black	E - American Indian, k, White, etc.
3 Wildowed 4 Divon		IF YES, GIVE W	AR OR DATES	S			2 X NO			, , , , , , ,		Spec	"y: White
15. DECE	DENT'S EDUCAT	ION	18	. DECEDENT'S	USUAL O	CCUPATIO	N		16b	. KIND OF BUS	INESS/IND	USTRY	
(Specify only Elementary/Secondary (0-	highest grade con	ollege (1-4 or 5 a	-)	(Give kind of w life, Do NOT us	e retired.)	during mos	at of working						
12				Homema	aker					Hcme			
17. FATHER'S NAME (First, Mid		TIMITO	7						_	Middle, Maiden			
	mes S.	LEWIS	<u> </u>					hel	I.	PRIC			
Mr. James T.		de Sr								ber, City or Town			
										, Md.			
20g. METHOD OF DISPOSITION 1 Description S Description	3 Removal	from State	cemeter Mary	y cremetory or of land Ve	her placa)	anc (Tomot	.10,	, 199	5 20c. Loc	risor		rest, Md.
		SEE	TIGLY	Tana ve	22.	NAME AN	D ADDRESS	OF FAC	LITY				
> Alla	m 94	D.C	21. SIGNATURE OF FUNERAL SERVICE LICENSEE ADD 9/ 10.00 M00703 22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home										
106 East Church St., Frederick, Md. 21/01											ederi		
23. PART i. Enter the dis	seases, or com	plications tha	aused th	e death. Do n									Md. 21701
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32. REGISTRANIS SIGNATURE
Fills Davilson Reveals

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **BALTIMORE, MARYLAND 21215-0020**

41. 10.

TO BE COMPLETED BY FUNERAL DIRECTOR

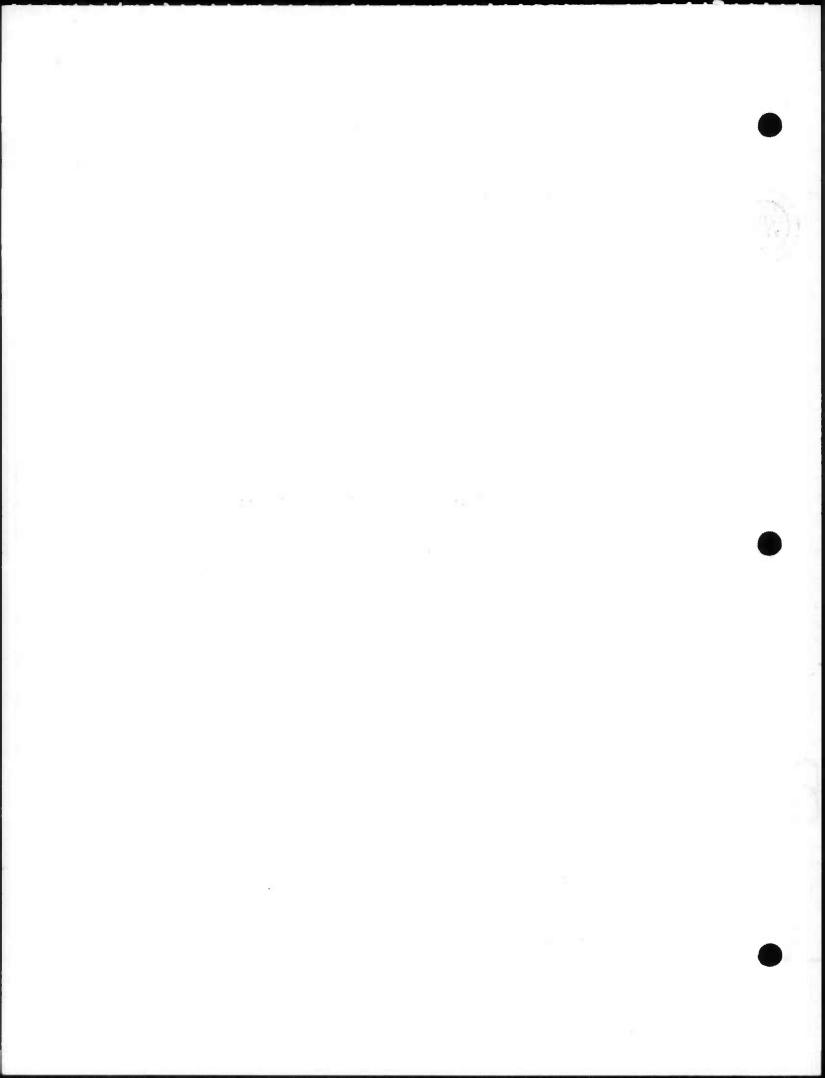
DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Month, Day, Year) FEB 08

DHMH-16 Rev 1/89



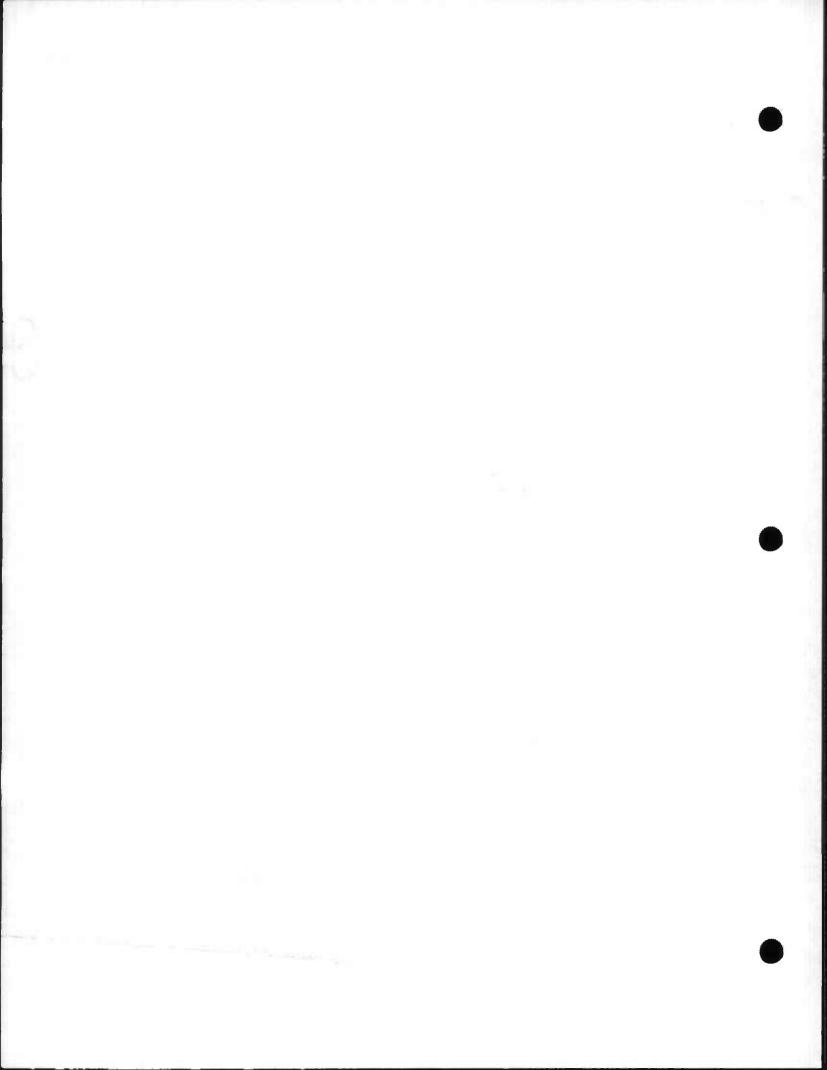
1 -	FOR STATE REGISTRAR

STATE OF MADVI AND / DEDADTMENT OF HEALTH AND MENTAL HIVOIR

	1 - STATE REGISTRAR	SIAIL OF MI	CE			OF DEA		MENIAL HYGIEN REG. NO.	Ŀ				
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH			3. TIME OF DEATH		
	Clarence	Ever	ett	RI	GHTSE	$\mathbf{L}\mathbf{L}$		MONTH 2	MA.	95	0606 AM		
	4. SOCIAL SECURITY HUMBER	5. SEX 6	. AGE (In yrs. lest	birthday)	IF UNDER 1 Y		R 24 HRS.	7. DATE OF BIRTH		6. BIRTI	IPLACE (State or Foreign		
	577-24-6144	1 🔀 M 2 🗌 F	83	YRS.	MONTHS D	AVS HOURS	MIN.	Dec 17, 19	911	Count	diana		
	Se. FACILITY NAME (If not institution, give str	pet and number)			9b. CITY, TO	WN OR LOCAT	ION OF D			JHTY OF D	EATH		
OR	Frederick Memoria	1 Hospita	1		Fr	ederic	k			Fred	erick		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			Taxable III									
E		lerick			y, town on i Freder						10d. INSIDE CITY LIMITS?		
	10e. STREET AHD NUMBER	CLICK			rreder						1 X YES 2 NO		
RA		•				10f. ZIP COD	=		10g. CI1		WHAT COUNTRY?		
FUNERAL	2459 Bear Den Roa			21701						U.S	.A.		
	1 Never Married 2 X Merried	12. WAS DECEDENT I	YES 2 N	0				NIC ORIGIN? (Specify Yes in, Puerto Rican, etc.)	or No-	14. RACI Blac	E — American Indian, k, White, etc.		
BY	3 Widowed 4 Divorced	3/19/194	3-12/5/1	1945	1 🗆	YES 2X NO	Specif	у:		Spec	™ White		
	15. DECEDENT'S EDUC	ATION	16a, DEC	EDENT'S	USUAL OCCU	PATION		16b. KIHD OF BUS	IMESS/IM	DUETOV			
H	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Giv	ne kind of to Do NOT us	work done durii se retired.)	ng most of work	ing	TOOL KIND OF BOS	IIIE33/IN	DUSTRI			
7	Control of Secondary (0-12)	3			igator			Civil	Serv	ice	Commission		
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)				J	16, MOT	HER'S NA	ME (First, Middle, Meiden :	Sumamai				
	UNKN	OWN				Ad			,	RI	GHTSEL		
) BE	19e. IHFORMANT'S HAME (Type/Print)		19b.	MAILING	ADDRESS (SI	reet and Numbe	r or Rural	Route Number, City or Town	, State, Zi	to Code)			
5	Mrs. Mary E. Righ	tsell						rederick,			21701		
	20e. METHOD OF DISPOSITION		20b. PLACE A	NDDATE	OF DISPOSITIO			DATE 20c. LOC					
	1 Burtel 2 Cremetion 3 Remo	val from State	Smith	netory or o	ther place)	natom	Fo						
	Smithsburg Crematory Feb 6, 1995 Smithsburg, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY												
- 3	Keeney & Basford P.A. Funeral Home 106 E. Church St, Frederick, MD 21701												
	22 PART I Enter the disease or a	- NO WES	MYV MC	00700	0 1106	E. Chu	ırch	St, Freder	ick.	, MD	21701		
	23. PART I. Enter the diseases, or co shock, or haert failure. L	ist only one ceuse	on asch iine.	ith. Do r	not enter the	moda of dy	ing, suc	h as cardlec or reapir	ratory ar	rest,	Approximata Interval Between		
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	resulting in death)		run	we		llime	-05	ent me	um	1246	4 days		
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CERTIFICATION	Sequentially list conditions, b.	DUE TO (O	R AS A CONSEQU	LIENCE OF	D.								
¥	If sny, lesding to immediate cause. Enter UNDERLYING			ochioe o	,-								
필	CAUSE (Disease or injury that initiated events	DUE TO (O	R AS A CONSEO	UEHCE O	F):						<u> </u>		
E	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST												
	DART II ON THE STATE OF												
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ME			10/2	- (90	0		′			1 TYES 2 NO		
ä	DID TOBACCO USE CONTR	BUTE TO CAU	SE OF DEAT	H YE	S NC	UNC	CERTAII	V 🗆					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE	OF DEAT	H (Check only	one)							
YS.		1 Inpatient 2 □ E	R/Outpetient 3	□ DOA	OTHER:	Home 5 🗆 R	esidence	6 Other (Specify)					
H	27. MAHHER OF DEATH	28a. DATE OF IN. (Month, Day,		28b. TIM	E OF 280 URY	WORK?		28d. DEŞCRIBE HOW IN	JURY OC	CURED			
BY	1 Hatural 5 Pending Investigation					YES 2] но						
	3 Suicide 6 Could not be	28e. PLACE OF II building, etc	NJURY — At home. (Specify)	ve, ferm, s	dreet, factory,	office		281. LOCATIOH (Street ar City or Town, State)	nd Numbe	r or Rural F	loute Number,		
	4 Homicide determined												
COMPLETED	29e. CERTIFIER (Check only 1 CERTIFYING PHYSIC	AH: To the best of my	knowledge, deal	th occurre	ed at the time,	date end place	, end due	to the cause(e) end mend	her as ate	ted.			
O	one) 2 MEDICAL EXAMIHER) and menner se stated.		
	29b. SIGHATURE AND TITLE OF CERTIFIER					-	ENSE HUN				(Month, Day, Year)		
R	AM Som					T	> 2	6516	> 7	21 2	95		
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (ITEM	27) (Type.	Print)		-	3.0			113		
	HIENJ GIC	am ho		47	5 .	TAME	1	A.10 F	LIP	W	771767		
	31. DATE FILED (Month, Day, Year)	32. RESISTBARY	SIGNATURE A	,		1 14.		1.0	14	/v 9	- 211		
	reB 06 1995	32. RESISTBARY	audust N	artal	16								

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-train. If them 28 is marked not them 20 is marked for use as the burial-train. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.



Or attending physics	or use as the burtal-thoost permit. Pages 1, 2, 3 sho)
YSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending payer.	but settificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buying the State Dent, of Health and Mental Hydiene prior to burial cremation, or removal	medical examiner must be notified at once.
requires that the death certificate be executed within 24	certificate has been signed by the attending physician and completely filled in the State Deat, of Health and Mental Hydiene prior to burial, cremation, or	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law	TO THE FUNERAL DIRECTOR: After this certificate has be he filed within 72 hours after death with the State Dent.	MPORTANT: if item 28 is marked, or item 23 s

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	HEGISTHAH			RHIF	CALE	PUEATH		REG. NO			
- A	1. DECEDENT'S NAME (First, Middle, Last)	1-1	Donis				MONT		AY	YEAR	3. TIME OF DEATH
	John D	onald 5. SEX	Rosier				Feb.		199		1:00 A M
	220-03-4283	1 X M 2 T F	6. AGE (In yrs. les	PRE DIRTHOUS DAYS HOURS MIN. WONTHS DAYS HOURS MIN. WORTHS DAYS HOURS MIN. Dec. 2					1920 BIRTHPLACE (State or Foreign Country) Maryland		
- 3	9a. FACILITY NAME (If not institution, give s		74		At 01771 7011	N OR LOCATION OF		. 24, 1			4
Œ	20325 Downes	,				ckton	DEATH			Ltim	
5	RESIDENCE OF DECEDENT	71044							124.		.010
Ä	10e. STATE 10b. COUNT			717	TOWN OR LO						10d. INSIDE CITY LIMITS?
ā	Maryland Bal	timore		Pa	arkto	n					1 TYES 2 X NO
FUNERAL DIRECTOR	10e. STREET AND NUMBER					101. ZIP CODE					WHAT COUNTRY?
5	20325 Downes	Road				21120			η υ.	S.A	
2	11. MARITAL STATUS 1 Never Married 2 X Married	12. WAS OECEDEN FORCES? 1	T EVER IN U.S. AR	MED	13. WAS C	ECENDENT OF HISP specify Cuban, Mexi	ANIC ORIGIN	17 (Specify Yes	or No-	14. RAC	E — American Indian, k, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		1 🗆 Y	ES 2 NO Spe	city:	, 000		Spec	
	15. DECEDENT'S EDU		16a DE	CEDENT'S II	SUAL OCCUPA	TION	1 404	. KIND OF BU	6141500 (H)	00750	WILLCE
	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5 -	(G	ve kind of wo Do NOT use	ork done during retired.)	most of working				DUSTRY	
립	8	College (I-4 of 3)		elde:	r			Steel			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S I	NAME (First, I	Middle, Maiden	Surname)		
BE O	Lewis Clifton	Rosier				Gert	rude	Eliz	abet	th E	nsor
TO B	19a. INFORMANT'S NAME (Type/Print)					t and Number or Run					
F	Dirothe M. Ro			2032	5 Dow	nes Rd.	, Pa:	rkton	, MI	21	120
	29. METHOD OF DISPOSITION 14N Burlal 2 Cremation 3 Rem	oval from State	20b. PLACE	ND DATEO	OISPOSITION	Name of	DAT	E 20c. LO	CATION -	City or To	own, State
	4 Donation 5 Dther (Specify)		Presby	yteri	an Cen	thel Fe	P995	Wh:	ite	Hal	1, MD
	21. SIGNATURE OF PUREIVAL SERVICE LI	TENHEE .	1		1 AZ. POME	. Harte	PROBLETT				
	* Hart X	farlen	stein	_	24	Second S	St., N	New Fr	reed	om,	PA 17349
	23. PART I. Eater the diseases, or	complications the	ceused the de	ath. Do no							Approximate
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. immediate/CAUSE (Final										
		. Ceca	BROVAS	culia	ne 14	CIMENT					2 mos.
	in doddi,	DUE TO	OR AS A CONSEC	UENCE OF)							12
Z	Sequentially list conditions,	n. Ceca DUE TO b. Athe	roscle	rotic	- Cer	elvo VAS	sculv	72 DI	SEVA	SE	
CERTIFICATION	if any, leading to immediate	DUE TO	OR AS A CONSEC	DUENCE OF)	:						
걸	cause. Enter UNDERLYING CAUSE (Disease or injury	c	OR AS A CONSEC	VIENCE OF							
Ē	that initiated events resulting in death) LAST	DOE TO	OH AS A CONSEC	IDENCE OF							i
S	The same of the sa	d									
	PART ii. Other significant condition	s contributing to	death but not n	esuiting in	the underly	ing cause given i	n Part I.	24a, WAS AN PERFOR		248	. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
EDICAL	Hyper tension							1 TES 2			COMPLETION OF CAUSE OF DEATH?
ME	Discustes Me	Hitrus								- (1 TES 2 NO
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				PLACE OF DEATH (Check only on	ne)			
PHYSICIAN:	1 NES 2 NQ	1 Inpetient 2	ER/Outpatient 3		OTHER:	ome 5 Residenc	6 🗆 Othe	r (Specify)			
표	27, MANNER OF DEATH 1 Netural 5 Pending	28s. DATE OF (Month, D.		26b. TIME INJU		NJURY AT WORK?	28d. DES	CRIBE HOW I	NJURY OC	CURED	
BY	1 Natural 5 Pending 2 Accident Investigation					YES 2 NO					
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE O building,	F INJURY — Al horate. (Specify)	me, 1erm, st	reet, factory, of	fice		ATION (Street or Town, State)		or Rural	Route Number,
E											
릴	29a, CERTIFIER (Check only one)										
COMPLETED	2 MEDICAL EXAMINE	R: On the basis of s	amination and/or i	nvestigation	, In my opinion	, death occured at ti	he time, dets	and place, an	nd due to t	he cause(s) and menner as stated,
BE	29b. SIGNATURE AND TITLE OF CERTIFIE					29c. LICENSE N	UMBER				(Month, Day, Year)
TO B	Michan Kus m	D ATT	ENDING	PHL	1SICIAN	m002	7283	E	F	FBRI	urry 10, 1995
-	30. NAME AND ADDRESS OF PERSON WH	O COMPLETEO CAUS	E OF DEATH (ITE	1 27) (Type, I	Print)	_					
		LURZ		VA	leys	PA 17	360				
- 1	31. DATE FILEO (Month, Day, Year)	32. REGISTRA	R'S SIGNATURE		,						
J	FEB 1 5 1995										

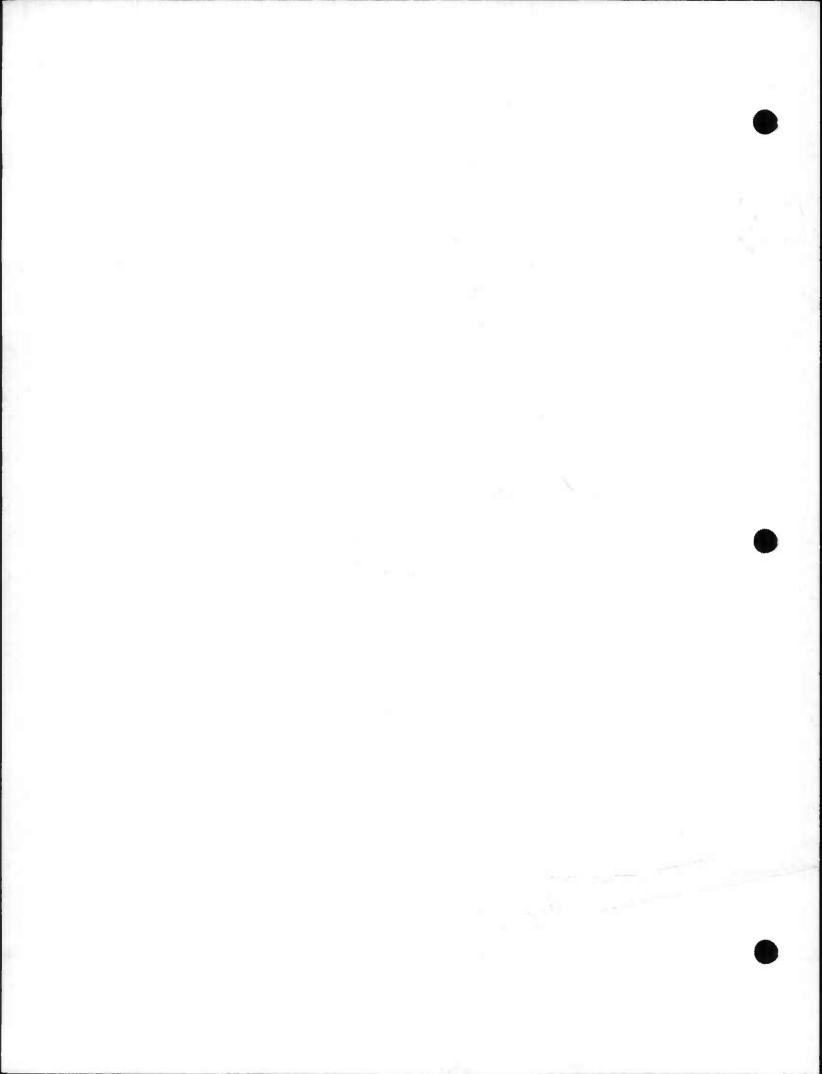


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BALTIMORE, MARYLAND 21215-0020	after death. Page 6 may be retained by the hospital or attending physician. The transit is the transit of the transit is provided to the contract of the purial-transit is provided to the contract of the purial-transit is provided to the contract of the purial-transit is provided to the contract of the provided to the contract of the

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red	eeu	0	8
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TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with. Thours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE REGISTRAR	SIAIL OF M	C	ERTIF	ICATE		EATH		REG. NO				
	1. DECEDENT'S NAME (Figst, Middlef Last) FLORINA			RA	FFC	2		2. DATE OF		M/ /	995	3. TIME OF DEATH P	
	4. SOCIAL SECURITY NUMBER 578-22-3148	1 🗆 M 2 💢 F	6. AGE (In yrs. Is		IF UNDER 1	YEAR IF I	INDER 24 HRS.	7. DATE OF (Month, E	Day, Year)	1925	Country	PLACE (State or Foreign ington, D.C.	
10R	96. FACILITY NAME (If not institution, give so Greater Laurel Ho RESIDENCE OF DECEDENT				96. CITY, T	-	CATION OF DI	EATH			inty of DE	eorges	
DIRECTOR	10a. STATE 10b. COUNTY	,	10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY	
	Maryland Prince	e Georges		Be1	tsvil.							1 TES 2 NO	
FUNERAL	11504 Blueridge D						705				10g. CITIZEN OF WHAT COUNTRY? USA		
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	EVER IN U.S. A YES 2 X AR OR DATES		If y	yes, specify	NT OF HISPAI Cuben, Mexica NO Specif	n, Puerto Ric		n or No—	14. RACE Black Specif	- American indian, Whita, atc. y: White		
ETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)			work done du se retired.)		working	16b. K	IND OF BU	SINESS/IN	DUSTRY		
COMPLET	12	2		rossi	ing Gu						e Dep	artment	
8	17. FATHER'S NAME (First, Middle, Last) John Muratori					1	MOTHER'S NA LUCY M	, ,		Surname)			
0	19a. INFORMANT'S NAME (Type/Print)					Street and Nu	mber or Rural	Route Number,	City or Tow				
	Michael Raffo						Drive						
	20a. METHOD OF DISPOSITION 1X Burtal 2 Cremation 3 Rem 4 Donation 5 Other (Specify)		ry crematory or other place! Mausoleum 2/3 Bres						entwood, Maryland				
	21. SIGNATURE OF FENERAL SERVICE LIE	in old -			11	1 008	Vew Har Sprin	mpshir	e Av	enue	di Fu 0904	neral Home	
RTIFICATION											Interval Batween Onset and Daath		
CE	PART ii. Other significent condition	a contributing to d	deeth but not	out not resulting in the underlying ceuse given in P					n Part i. 24s. WAS AN AUT			WERE AUTOPSY FINDINGS	
MEDICA						,			PERFO	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
AN: M	DID TOBACCO USE	CONTRIBUTE	TO CAL	JSE O	F DEATI		OF DEATH (Ch	- 1				1 YES 2 NO	
PHYSICIAN:	EXAMINER?	HOSPITAL:	ER/Outpatient	3 DOA	OTHER:		Residence		Specify)				
BY PH	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26e. DATE OF I (Month, Day	INJURY y, Ybar)	26b. TIN	JURY M	6c. INJURY WORK? 1 YES		28d. DESCR	RIBE HOW	NJURY O	CCURED		
	3 Suicide 6 Could not be determined	28a. PLACE OF building, a	INJURY — At h	nome, farm,	street, tector	y, offica		281. LOCATI City or	ION (Street Town, State,	and Numbe	or or Rural R	oute Number,	
COMPLETED	and)	CIAN: To the best of r										and menner as stated.	
IO BE C	29b. SIGNATURE AND TITLE OF CERTIFIES 30. NAME/AND ADDRESS OF PERSON WH	COMPLETED CAUSE	E OF DEATH (IT	EM 27) (Type	, Print)	0	LICENSE NUI	MBER 79	0/-	29d. DA	TE SIGNED	(Month, Day, Year)	
	31. DATE FILED (Morith, Day, Year) FEB U3 1995	32 pecistras	signature	0/ /	1/284	TON	DR.	LAT	60	M	DÓ	10772	
_													



	1 - STATE REGISTRAR	CE	RTIF	ICATE O	F DEA	TH III	REG. NO	_			
	1. DECEDENT'S NAME (First, Middle, Last)					T	2. DATE OF DEATH		3. TIME OF DEATH		
	MARIE MARGARET RAMSEY						January 2	3.1995	AR 1150 A M		
	4. SOCIAL SECURITY NUMBER 5. SEX 6	- AGE (In yrs. last	birthday)	IF UNDER 1 YEA		24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. 1	BIRTHPLACE (State or Foreign		
	578-58-9643 ¹□м²⊠г	90	YRS.	MONTHS DAY	HOURS	MM.	May 3,1904		Country) .OWa		
	Se. FACILITY NAME (If not institution, give street and number)			9b. CITY, TOW				9c. COUNTY	OF DEATH		
OHO!	CARRIAGE HILL - BETHESDA			BETHE	SDA			MONTGO:	MERY		
DIRECTOR	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LO	CATION				10d. INSIDE CITY		
DIR	none none					C			LIMITS?		
7	104. STREET AND NUMBER		V	ashing	101. ZIP COD			10a, CITIZEN	1 YES 2 □ NO OF WHAT COUNTRY?		
ER/	4520 Windom Place, N.W.				200	16					
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT E			13. WAS 0	ECENDENT C	F HISPANIC	C ORIGIN? (Specify Yes	or No- 14.	RACE — American Indien.		
BY F	1 XNever Merried 2 Merried FORCES? 1 IF YES, GIVE WAR	OR DATES	0	If yes,	specify Cube ES 2 🔯 NO	n, Mexican, Specify:	Puerto Rican, etc.)		Black, White, etc. Specify:		
									hite		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(GA		WORK done during		og	16b. KIND OF BU	SINESS/INDUST	RY		
7	Elementary/Secondary (0-12) College (1-4 or 5 +)			nal rel	ah da	-1-	11.0		-		
W _O	17. FATHER'S NAME (First, Middle, Lest)	1 000	atio	nai lei			E (First, Middle, Maiden	Governm	ent		
	Robert J. Ramsey				1110		orbeck	Surrieme)			
BE	19a. INFORMANT'S NAME (Type/Print)	19b	MAILING	ADDRESS (Stre			oute Number, City or Tow	n, Stete, Zip Cod	(a)		
임	A. Catherine Poore						N.W.,Wash.				
	20a. METHOD OF DISPOSITION 1 ◯ ☐ Burlel 2 □ Cremation 3 □ Removal from State	20h PLACEA	NODATE	DE DISPOSITION	Nome of		DATE 200 LO	CATION CIN	as Town Chats		
	4 Donation 6 Other (Specify)	Gate Gate	of H	eaven (Cemete	ry Ja	an. 27, 95 S	Silver	Spring, Md.		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	1		22. NAME De Vo	AND ADDRES	era	uty Home				
	James Cl Hollas							I. Wash	.,DC 20007		
	23. PART I. Enter the diseases, or complications that of	avaed the dea	ith. Do r	ot enter the	node of dyl	ng, auch	an cardiac or raspi	ratory arrest,	Approximata		
	ehock, or heart fallure. List only one cause	on each line.		. ,		,			Interval Between Onset and Daeth		
	disease or condition resulting in death)										
		R AS A CONSEO	UENCE O	Di.	1	1 -	``				
N	Sequentially list conditions, b.	riosoli	prot	ic He	Part		15000				
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	AS A CONSEO	UENCE O	F):							
임	CAUSE (Disease or Injury C.	R AS A CONSEO	UENCE OF	F):							
E	resulting in death) LAST								į		
	DATE II ON THE RESERVE OF THE RESERV										
DICAL	PART II. Other algnificant conditions contributing to de		eulting	in the underly	ing ceuse g	iven in P	art I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
ă	- Ineymon		1				1 _ YE\$ 2	NO	COMPLETION OF CAUSE OF DEATH?		
ME	Obstruchi		1/m	MOL	0/150	250			1 - YES 2 - NO		
AN	DID TOBACCO USE CONTRIBUTE TO CAUS 25. WAS CASE REFERRED TO MEDICAL			S □ MO		ERTAIN	И				
PHYSICIAN:	EXAMINER? HOSPITAL:			H (Check only or OTHER:							
H	1 YES 2 M NO 1 Inpatient 2 E 27. MANNEB OF DEATH 289. DATE OF IN.		28b. TIM		ome 5 Re		Other (Specify)				
	1 Natural 5 Pending (Month, Day,	Year)		URY	YES 2		28d. DESCRIBE HOW I				
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	NJURY — At hor	ne, farm, s				281. LOCATION (Street o	nd Number or R	ural Route Number		
COMPLETED	4 Homicide determined building, atc	(Specify)					City or Town, State)	_			
7	29e. CERTIFIER (Check only (Ch	knowledge, dea	th occurre	d at the time d	te end plece	and due to	the cause(s) and mos	mar on atota d			
X	one) 2 MEDICAL EXAMINER: On the besis of exam								use(e) end menner as stated.		
Ü U	29b. SIGNATURE AND TITLE OF CERTIFIER					NSE NUMB			INED (Month, Day, Year)		
0	- Als Innha	MO			,7	1102	24	> //	77/55		
일	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE	OF DEATH (ITEM	27) (Туре,	Print)	101		/	1	-3/13		
	John S. Umhau M.	1), 8	FOS	Conn	1. fa	P., ((mre)	M	208-15		
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S	SIGNATURE		•							
	JAN 30 1995 Alia Davids	ortandal	6								

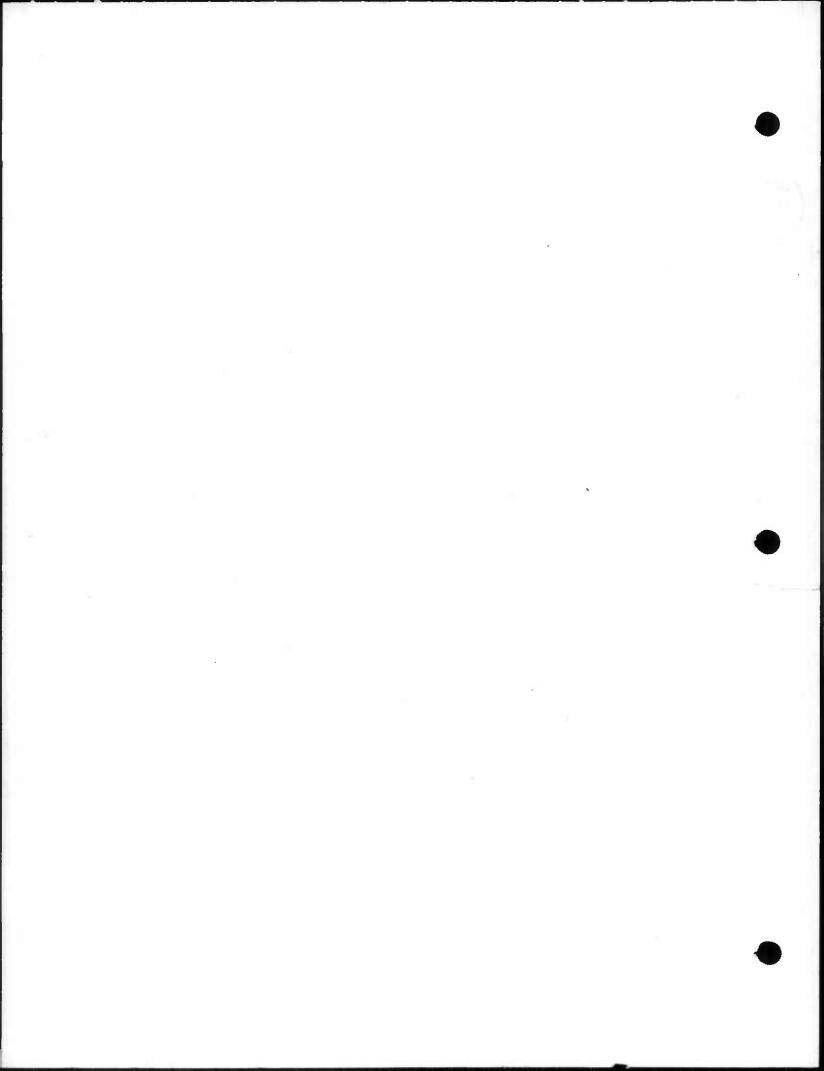
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 10 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit is filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-16 Rav 1/89



	a willing the hours and deam. Page to may be retained by the hospital or attending moletely filled in by the funeral director page 5 should be detached for use as the	, cremation, or removal.	went, the medical examiner must be notified at once.	
TO THE LINEDITAL OF ATTENDING DENCHARITY AND THE STANDARD SHE SHOULD BE SHOU	TO THE MOSTIAL OR ALLEMOND PRINCIPLY THE LAW ENGINES WHI UP DESIDED OF WHITE A NOT'S SIGN DESTREAMEN BY THE PRINCIPLY OF THE LAW OF PRINCIPLY OF THE LAW O	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

DIVISION OF VITAL RECORDS, P.O. BOX 68760

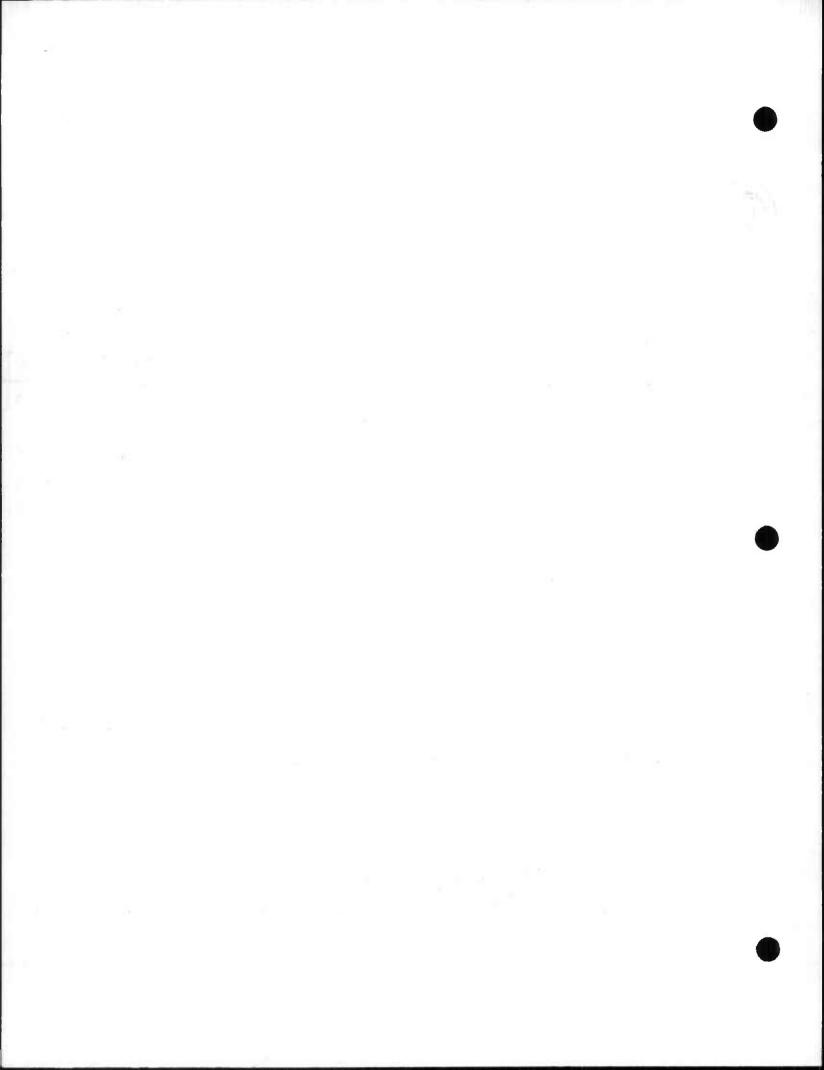
BALTIMORE, MARYLAND 21215-0020

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

1 DECEMBRY: NAME (FIRST MARKE)

	REGISTRAR		-		OF THE	F DEATH		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, List) 2. DATE OF DEATH 3. TIME OF DEATH									DEATH		
		ber			MON		YEAR	Я				
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. le		IF UNDER 1 YEA	IF UNDER 24 HRS.		Uary 3	0, 19	_	L 2:20	Α •••
	CONTRACTOR CONTRACTOR	1 ¥ XM 2 □ F			MONTHS DAY		(Mo	nth, Day, Year)		Count	HPLACE (State :	or Foreign
	214-22-8388	1 1 1 1	83	YRS.			Jun	e 22,	1911	Sou	th Dak	cota
ph :	Sa. FACILITY NAME (If not institution, give	street and number)			9b. CITY, TOY	N OR LOCATION OF D	EATH		9c. COU	NTY OF D	PEATH	
H	3663 Edelmar 1	errace			Silve	r Spring			Man	+		
H	RESIDENCE OF DECEDENT	011000			DITAG	T Spiring			I MOL	ntgom	nery	
DIRECTOR	10a. STATE 10b. COUN	ITY		10c. CITY	, TOWN OR LO	CATION					10d. INSIDE	CITY
15	Maryland Mor	ntgomery		041	C-						LIMITS?	
	10e. STREET AND NUMBER	regulier y		1 OTT	ver Sp	10f. ZIP CODE					1 YES 2	
FUNERAL					1	72. 74.4 74.75			10g. CIT	IZEN OF V	WHAT COUNTR	147
4	3663 Edelmar Ter	race				20906			Uni	ted	States	3
5	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. A	RMED	13. WAS	DECENDENT OF HISPA	NIC ORIG	IN? (Specify Yes	or No-	14. RACE	E — American k, White, etc.	Indian,
7	1 Never Married 2 🔀 Married	FORCES? 1 X	R OR DATES	NO	If yea	specify Cuban, Maxic (ES 2 X NO Speci	an, Puart	o Rican, etc.)		Speci		
BY	3 Widowed 4 Divorced		WW II			A(a)	.,.				ite	
0	15. DECEDENT'S EC	DUCATION	16a. DI	ECEDENT'S	USUAL OCCUP	ATION	1	Bb. KIND OF BUS	SINESS/INI		1100	
E	(Specify only highest gra		(C)	Give kind of we. Do NOT use	rork done during	most of working						
7	Elementary/Secondary (0-12)	College (1-4 or 5+)						11 0 0	2004	- 6	01-1-	
Σ		5	UII	icer o	t Public	health		U. S. C		01	State	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S N.	AME (First	, Middle, Malden	Surname)			
BE	Daniel D. Rab	er				Julia	Ma	e Van	Dore	n		
	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (Stre	et and Number or Rural	Route Nu	mber City or Tow	n. Stete Zi	n Code)		
5	Doris E. RAber				as 10			mont only or low	ri, Otato, Ly	0000)		
							-	-				
	20a. METHOD OF DISPOSITION 1 Durial 2 X Cremation 3 Re	movel from State	20b. PLACE cametery, cri	and DATE O ematory or oti	F DISPOSITION	(Name of			CATION —			
	4 Donation 5 Other (Specify)		Che	esapea	ake Cr	ematory	1-	30 Belt	svil	le,	Maryla	nd
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE			22. NAMI	AND ADDRESS OF F	ACILITY					
	Den.	1 Ko	00			Rapp Funeral Services, P. A.						
_	Cillen K	1.	77		933	Gist Ave	nue.	Silver	Spr	ina.	MD 20	910
	23. PART I. Enter the diseases, or	r complications that	caused the de	eath. Do n	ot enter the	mode of dying, suc	ch as ce	rdiac or respi	retory er	rest,	Approx	kimate
	shock, or heart fellure	r complications that' b. List only one caus	caused the de e on each ilne	a.	ot enter the	mode of dying, suc	ch as ce	rdiac or respi	iretory er	rest,	Approx	i Between
	shock, or heart feilure IMMEDIATE CAUSE (Final disease or condition	complications that	caused the de e on each line	a.	ot enter the	mode of dying, suc	ch as ce	rdiac or respi	retory er	rest,	Approx	
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FOR

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

* REGISTRAR			CE	RTIF	ICATE	OF DEAT	TH	RE	G. NO.		
1. DECEDENT'S NAME (First,	Middle, Last)							2. DATE OF DE	ATH		3. TIME OF OEATH
WALTE	R	EMTT	. RO	DBERT	CSON			JANUA	RY 23	, 1995	3:00 pm
4. SOCIAL SECURITY NUME		. SEX	6. AGE (In yrs. last		IF UNDER I	YEAR IF UNDER	24 HRS.	7. DATE OF BIE	TH		HPLACE (State or Foreign
578-68-661	5 1	X M 2 □ F	44	YRS.	MONTHS	DAYS HOURS	MIN.	July	26. 19	950 Count	
9e. FACILITY NAME (# not in		t and number)			9h CITY I	TOWN OR LOCATI	ON OF DE			COUNTY OF E	
U. S. Post	Stre ashingto	et n		ockville					tgomery		
10e. STATE	10b. COUNTY			10c. CIT	Y, TOWN OR	LOCATION			-		10d. INSIDE CITY
Md.	Mon	taomerv			Cit	tros Cos					LIMITS?
10e. STREET AND NUMBER	PIOII	rdomer A			211	Lver Spi			100	CITIZEN OF	WHAT COUNTRY?
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17. FATHER'S NAME (First, M	iddle, Last)					18. MOT	HER'S NAI	ME (First, Middle,	Maiden Suma	ime)	
L. George	Roberts	on					Lvc	dia Russ	sell		
19e. INFORMANT'S NAME (7			196	. MAILING	ADDRESS (Street and Number				te, Zip Code)	
Ethel D.	Robert	son				ec Stree					
200. METHOD OF DISPOSIT	ON		20b. PLACE A							ON City or To	own. Siste
1- Buriel 2 Crametic	n 3 Removal (Specify)	I from State	cemetery, crer			- mi - 1		1/20		•	
21. SIGNATURE OF FUNERA				шопұ	7 Memo	AME AND ADDRE	SS OF FAC	CILITY	Land	over, l	Ma.
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23. PART I. Enter the di	aeasee, or com	plicatione the	t ceueed the de	eth. Do n	not enter ti	he mode of dy	ing, such	ae cerdiac Di	r respirator	y arrest,	Approximata
ahock, Dr h	eert feilure. List	t only one ceu	ee on each iina.								interval Between Onset and Deeth
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Swiles Radall

BALTIMORE, MARYLAND 21215-0020

Managarah

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a formus after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FEB 01

1995

DHMH-16 Rev 1/69

020	physician.	burial-trans		Total	10.00
BALLIMORE, MARYLAND 21215-0020	e hospital or attending	etached for use as the		nce.	
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20000	be executed within 24 I	cian and completely fille	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	aumatic event, the	
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	4. SOCIAL SECURITY NUMBER	s. SEX	6. AGE (In yrs. les	st birthday)	IF UNDE	R 1 YEAR	IF UNDER	1 24 HRS.	Janu 7. DATE O		0, 199		8:30 A M
	487-06-3054	1 🕅 M 2 🗆 F	80	YRS.	MONTHS		HOURS	MIN.	(Month,	6, 1		Country) Ind	
_	9a. FACILITY NAME (If not institution, give s				9b. CIT	Y, TOWN	R LOCATI	ON OF DE		-, -		TY OF DEAT	
DIRECTOR	1135 University	Blvd., W	lest		_Si	lver	Spri	ing			IOM	ntgom	ery
REC	10a. STATE 10b. COUNT	Y		10c. CIT	Y, TOWN	OR LOCAT	ION					10	d. INSIDE CITY
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F	1 Never Married 2 Married	FORCES? 1	YES 2 XI	NO	13.	If yes, spe	ecity Cuba	m, Mexical	n, Puerto R	(Specify Yellican, etc.)	or No—	14. RACE — Black, W Specify:	American Indien, fhite, atc.
Э ВУ	3 X Widowed 4 Divorced							эрвспу					dian
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	completed)	(G	CEDENT'S live kind of to DO NOT us	work done	during mo.	st of workin			KIND OF BU	SINESS/INDU	ISTRY	
PLE	Elementary/Secondary (0-12)	College (1-4 or 5 d	·)	trict			_	fice		OVERNI	ment o	of In	dia
Ö	17. FATHER'S NAME (First, Middle, Last)		1013	10 L L 10 L	. 1111	UUS (,)		HER'S NAI		iddle, Maiden		OT TIL	010
BE (Devi Dayal							una	Devi				
욘	19a. INFORMANT'S NAME (Type/Print)										n, State, Zip		7.0
	Sajay Rai		20b. PLACE					NO			CATION - C		
	20a. METHOD OF DISPOSITION 1	ovel from State	cometery, cre	ametery or p	ther place	remat	me or						aryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	1	арсан	22.	NAME AN	D ADDRES	SS OF FAC	CILITY				arytanu
	> Eleen	W. 1	Rapa	0		Rapp	Fune	eral	Serv	ices,	P. A.		up 00010
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory streat, shock, or heart fellure. List only one cause on each line.												
	IMMEDIATE CALLSE /FInel												Onset and Death
	disesse or condition resulting in death)	· ante				- 1	tea	5-7	D	1500	عد	`	
_		DUE TO	(OR AS A CONSE	OUENCE O	F):								
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSEC	OUENCE O	CE OF):								
CA	cause. Enter UNDERLYING CAUSE (Disease or injury	с											
TIF	thet initiated events resulting in death) LAST	DUE TO	(OR AS A CONSE	OUENCE O	7):								
CEF		d											
SAL	PART II. Other significent condition	is contributing to	deeth but not r	resulting	n the u	nderlying	ceuse g	given in I	Part I.	24a. WAS AN PERFOR		AM	RE AUTOPSY FINDINGS AILABLE PRIOR TO
MEDICAL									-	1 TYES 2	NO X		MPLETION OF CAUSE DEATH?
	DID TOBACCO USE CONT	RIBLITE TO CA	LISE OF DEA	TH YE	s 🗆	NO [LINC	ERTAIN				1 [YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			E OF DEAT			OIVC	EKIAII	1 1				
SIC	EXAMINER? 1 \(\text{YES} 2 NO \)	HOSPITAL: 1 Inpatient 2	ER/Outpatient 3	□ DOA	OTHE 4 Nu		5 🗘 Re	aldence	6 🗆 Other	(Specify)			
PH	27. MANNER OF DEATH	28a. DATE OF (Month, De		28b. TIM	E OF URY	28c. INJI	JRY AT		28d. OE\$0	28d. OESCRIBE HOW INJURY OCCURED			
ВУ	2 Accident Investigation	20. 51.105.0			М		ES 2 [NO					
ED	3 Suicide 6 Could not be detarmined	building,	F INJURY — Al ho atc. (Specify)	ma, Iarm, (itreet, fac	tory, office			261. LOCA	TION (Street in Town, State)	and Number o	r Rural Rout	Number,
Ē	29a. CERTIFIER 1 CERTIFYING PHYSI	CtAN: To the best of	my knowledge de	eth occum	ed ant then	time date	and place	and due	to the same	-103 0-4			
COMPLETED	(Check only one) 2 MEDICAL EXAMINE												d mariner as stated,
BE C	296. SIGNATURE AND TITLE OF CENTHFIE							NSE NUM					onth, Day, Year)
TO B	263")	scelin	- 1	>			D	085	46				30, 1995
F	30. NAME AND ADDRESS OF PERSON WH	O COMPLETEO CAUS	SE OF DEATH (ITE	M 27) (%ne	Print)							-	

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

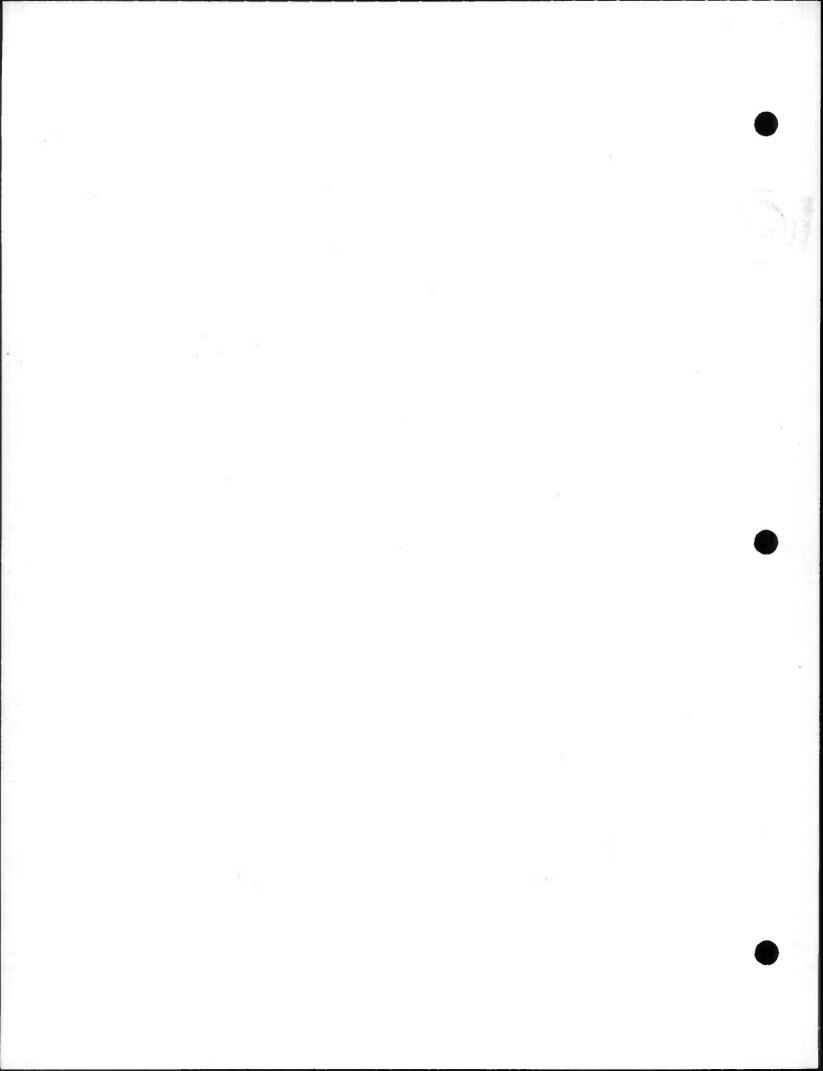
John F. Tauber, M. D.,

31. DATE FILED (Month, Day, Veer)

FEB 01 1995

D., 8218 Wisconsin Avenue, #318, Bethesda, MD 20814
32. GEOISTRAP'S SIGNATURE.

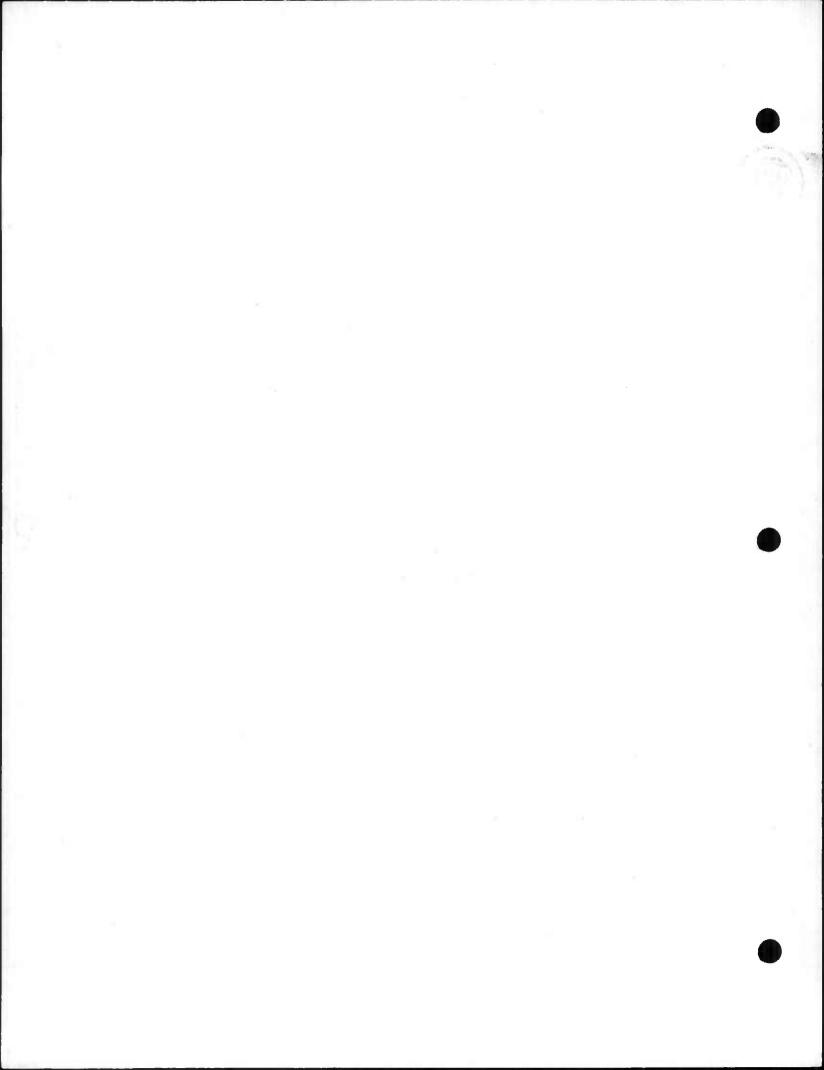
OHMH-18 Rev 1/89



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)				ords	MONT	2. DATE OF DEATH DAY YEAR January 27, 1995			3. TIME OF DEATH 3:05 PM
3	4. SOCIAL SECURITY NUMBER 209-14-0835	5. SEX 6. AC	6. AGE (In yrs. last birthday) 70 YRS.		IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Sept. 9,		8. BIRTH	IPLACE (State or Foreign
OR	9a. FACILITY NAME (If not institution, give st 5101 River Road				OR LOCATION OF DI			Montgomery		
DIRECTOR	PRESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		TY, TOWN OR LOCA	NTION				10d. INSIDE CITY		
	Maryland Monto	gomery	l B	ethesda 1	of ZIP CODE			10g. CITI	1 YES 2 NO	
FUNERAL	5101 River Road,	12. WAS DECEDENT EVE	R IN U.S. ARMED	13 WAS DE	20816-15 CENDENT OF HISPA		12 (Speek) Yes			States
B	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 X YE IF YES, OIVE WAR OF 6/14/43 -	es 2 □no R dates 4/24/46	If yes, s	pecify Cuban, Mexica B 2 XXNO Specif	en, Puerto	rr (specify rea Ricen, etc.)	or No-	Speci	- American Indian, t, White, atc. dy: Vhite
COMPLETED	15. DECEDENT'S EDU((Specify only highest grade) Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Give kind of	s usual occupat work done during muse retired.)	ost of working	16b	Autom			
COM	17. FATHER'S NAME (First, Middle, Last)		1 WHOTES	gie ryer	18. MOTHER'S NA	ME (First, I			3	
BE	Harold E. Richar	rds	10h MAII IN	O ADDRESS (Street	Jessie					
2	Arvilla Richards	3		me as 10		HOUTE NUM	oer, City or low	n, Stata, Zip	Code)	
	20a. METHOD OF DISPOSITION 1	ovel from State	20b. PLACE AND DATE	OF DISPOSITION (A	ame of	DAT		9c. LOCATION — City or Town, State		
	21. SIONATURE OF FUNERAL SERVICE LIC	ENSEE	Chesapeake Crematory 22. NAME AND ADDRESS OF FACILIA Rapp Funeral Se				1-28 Beltsville, Marylan			
	· Clun	W. Ka	pp	933 G	ist Aven	ue. S	Silver	Spri	na.	MD 20910
	23. PART I. Enter the diseases, or cahock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause on	esch line.		ode of dying, suc	th as care	diac or respi	ratory arr	est,	Approximata interval Between Oneet and Daeth
_	Tooling III double)		r Failure OR AS A CONSEQUENCE OF: SCRIPTION Dispass congenital							
CATION	Sequentielly list conditions, if sny, leading to immediate csuss. Enter UNDERLYING Due to (or as a consequence of):									
CERTIFICATION	CAUSE (Disease or injury that initieted events resulting in death) LAST	DUE TO (OR AS	(OR AS A CONSEQUENCE OF):							
AL	PART ii. Other significent conditions	a contributing to deeth	but not reaulting	ut not resulting in the underlying cause given in Part i.				AUTOPSY MED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
PHYSICIAN: MEDIC				1				1 _ YES 2 X NO		COMPLETION OF CAUSE DF DEATH? 1 YES 2 XNO
N.	DID TOBACCO USE CONTR	RIBUTE TO CAUSE			UNCERTAIL	N 🗆				
SICI	EXAMINER? 1 YES 2 XNO	HOSPITAL:		OTHER:	ne 5 XRasidence	6 T Other	- (Smarks)			
	27. MANNER OF DEATH 1 X Netural 5 Pending	28a. DATE OF INJUR (Month, Day, Year	Y 28b. TII	JURY 28c. IN		28d. DESCRIBE HOW INJURY OCCURED				
ED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28a. PLACE OF INJU building, atc. (S)	RY — At home, farm, pecify)	street, factory, offic		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				oute Number,
LETI	A. A. A. A. A. A. A. A. A. A. A. A. A. A	CIAN: To the best of my kno	owledge, death occur	red at the time date	and place, and due	to the cau	see(e) and man	nor on white	4	
COMPLETED		R: On the beels of examinar								and manner as stated.
띪	286. SIGNATURE AND TITLE OF CERTIFIER	M. Cm	nhon		29c, LICENSE NUN					(Month, Day, Year) y 27, 1995
2	30. NAME AND ADDRESS OF PERSON WHO Andrew N. Umhau,		DEATH (ITEM 27) (Type)1 new Mex		nue MM	#3/10	Mach			
	31. DATE FILED (Month, Day, Year) JAN 30 1995	32. REGISTRAR'S SIG	GNATURE		106, 1444,	πJ40	, wasi	ıııgcı	UH,	חר קחחדף
	2411 90 199t	5 Julia Dave	wor hardall							DHMH-16 Rev 1/89



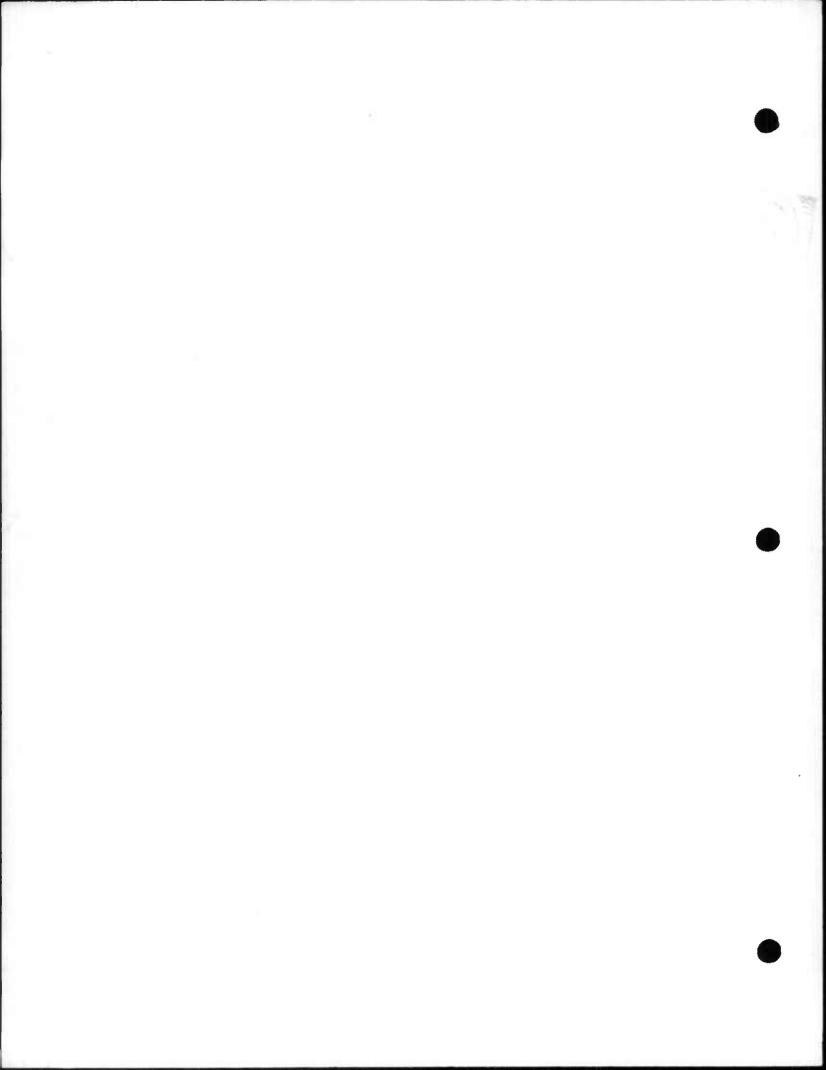
111	N	H	mit. Pages 14, 3 should	7
	BALTIMORE, MARYLAND 21215-0020	fter death. Page 6 may be retained by the hospital or attending physicum	the funeral director, page 5 should be detached for use as the burial-manning oval.	9300
	MARYL	retained by	5 should be	notified at
	IMORE,	Page 6 may be	al director, page	al examiner must be notified at once.
	BALT	fter death.	the funera	al exam

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing the flower after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE REGISTRAR	STATE OF MAR	YLAND / DEPAI CERTIF	RTMENT	OF HEALT	H AND	MENTAL HYGIE	,		0
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH	-		3. TIME OF DEATH
		Herbert Wa	alton Rut	ledge			January 3	BO. 19	YEAR	7:50 AM
	4. SOCIAL SECURITY NUMBER		GE (In yrs. lest birthday)	IF UNDER 1		DER 24 HRS.	7 DATE OF BIRTH		0. (0.007)44	N AGE (Otate on Francisco
	578-18-5045	1 🖾 M 2 🗆 F	74 yrs.	MONTHS	DAYS HOUR	s mn.	April 29,	1920	Country	Maryland
-	9a. FACILITY NAME (If not institution, give s			1	OWN OR LOC				NTY OF DE	ATH
DIRECTOR	3591 South Leisur	e World Blv	7d.	Sil	ver Sp	ring		Mont	tgome	ery
E C	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	19c. CI	TY, TOWN OR	LOCATION					10d. INSIDE CITY	
E C	Maryland Mont	1.0	Silver Spring						LIMITS?	
7	10e. STREET AND NUMBER			10f, ZIP C			10a, CITI	-	1 YES 2 X NO	
FUNERAL	3591 South Leisur	d.		20	906			USA		
S C	11. MARITAL STATUS	12. WAS DECEDENT EVE							14. RACE	— American Indian, White, atc.
BY F	1 Never Married 2 X Married 3 Widowed 4 Divorced	FORCES? 1 X Y	R DATES		yes, specify Cu YES 2 💢 N		an, Puerto Rican, atc.)			white, atc. White
		WWI		_						
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	completed)	16a. DECEDENT'S	work done du	CUPATION ring most of wo	orking	16b. KIND OF B	USINESS/IND	USTRY	
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Sales R				Offic	o Sunt	1100	
NO.	17. FATHER'S NAME (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	bares it	cpres			AME (First, Middle, Maide		TIES	,
Ö W	Herbert W. Rutled	ge. Sr.			1000		Shriner	n Sumame)		
0	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Route Number, City or To	wn. State. Zin	Codel	20906
2	Mary R. Rutledge									g,MD 20901
	20a. METHOD OF DISPOSITION		20b. PLACE AND DATE	OF DISPOSIT				OCATION —		
	1 M Buriat 2 Cremation 3 Removed from State A Donation 5 Other (Specify)								g,Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc.									
	Synthemic	9 Caush	11h				y Blvd.W.			
	23. PART I. Enter the diseases, or o	complications that ceu	sed the daeth. Do							Approximate
	IMMEDIATE CAUSE (Fine)									Interval Batween Onset and Death
disease or condition resulting in deeth) Cardiovascular Collapse										Minutes
	22 - 11 15 - 15 - 15 - 15 - 15 - 15 - 15	OUE TO (OR /	AS A CONSEQUENCE O	F):						
Sequentially list conditions,										
RTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR A	AS A CONSEQUENCE O	F):						
	CAUSE (Disease or injury that initiated events	cDUE TO (OR /	AS A CONSEQUENCE O	F :						
	resulting in deeth) LAST	d								
5	PART ii Other significant condition		h h							
								AVAILABLE PRIOR TO		
Cerebrovascular Disease DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)							COMPLETION OF CAUSE OF DEATH?			
							1 TES 2 NO			
2	EXAMINER? 1 X YES 2 NO		195507							
1 Notes 2 No 1 inpetient 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 National Residence 8 Other (Specify) 27. MANNER OF DEATH 28. DATE OF INJURY (Month, Day, Year) 28. DATE OF INJURY NORTH										
									i.	
							oute Number,			
S		R: On the besis of axemin								and manner as stated.
29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)										
	Harref W. 11	Junes	m. D		1	D0211	2			у 30, 1995
-	MANUE AND ADDRESS OF PERSON WH									
	Harold W. Draper,	M.D. 9801	Georgia	Avenue	2 1	Wheat	on, MD 209	902		
	31. DATE FILED (Month, Day, Year)	JE REGISTRAR'S S	IGNATIONE OLD III			-				
	FEB 01 1995	faux a min	an a many							

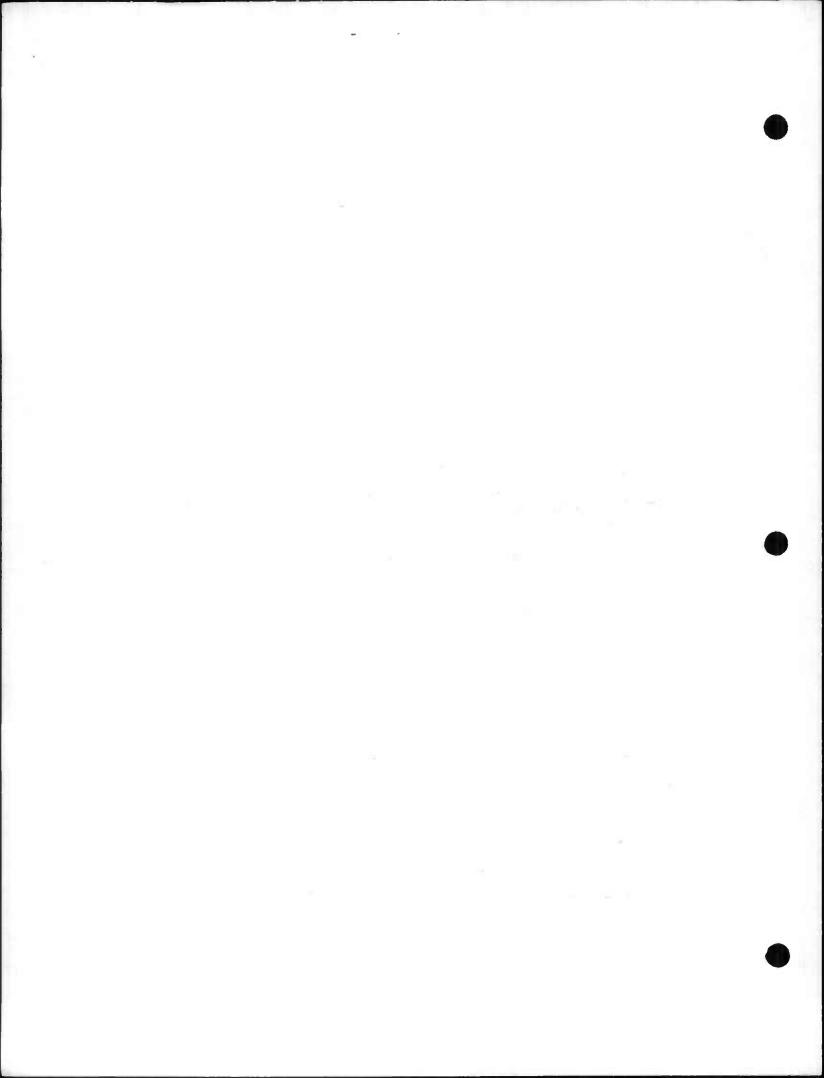


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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physic	DAY DISCOUNT AND AND AND AND AND AND AND AND AND AND
	A	
	-	C

be retained by the hospital or attending physical TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burn be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: If item 28 is marked. or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

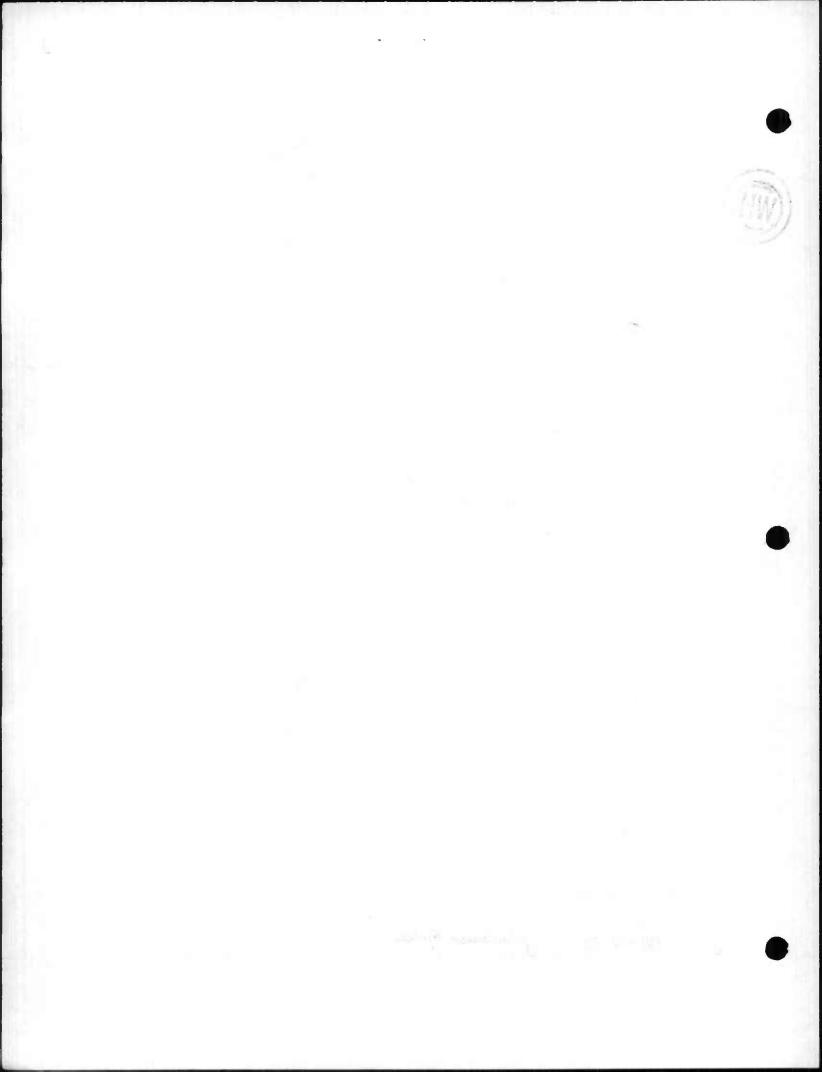
	FOR 1 - STATE REGISTRAR		STATE OF I	MARYL	AND /	DEPAF RTIF	RTMENT	OF H	IEALTH DEA	AND	MENT	TAL HYGIEN REG. NO.			
	1. DECEDENT'S NAME (Firs.		NETH SAUN	DERS			•				MO	NUARY	Ĭ,199	YEAR	3. TIME OF DEATH 1:40 A M
	4. SOCIAL SECURITY NUMBER 208-10-3155		5. SEX 1 😾 M 2 🗌 F	6. AGE (in yrs. iasi	t birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDE	R 24 HRS.	7. DA (M	TE OF BIRTH onth, Day, Year)		8. BIRTH Country	PLACE (State or Foreign
Œ	9a. FACILITY NAME (If not is	nstitution, give s			04					ION OF DI		LODEL 24	9c. COU	NTY OF D	
DIRECTOR	Magnolia Hall Nursing Home RESIDENCE OF DECEDENT 100. STATE 100. COUNTY								rtow	1			Ke	ent	
NE O	Maryland Kent						y, rown o		111247						10d. INSIDE CITY LIMITS? 1 X YES 2 NO
I I	100. STREET AND NUMBER								7. ZIP COD	_			10g, CIT		THAT COUNTRY?
11. MARITAL STATUS 1 Never Married 2 Merried 3 W Widowed 4 Divorced 12. WAS DECEDENT_EVER IN U.S. ARMED FORCES? 1 \(\times \) YES 2 \(\times \) NO If yes, specify Cuban, Mexican, Puerto Rican, 1 \(\times \) YES 2 \(\times \) NO Specify:						GIN? (Specify Yes to Rican, etc.)	or No—		— American Indian, , White, atc.						
8		EDENT'S EDU			18a. DE(CEDENT'S	USUAL O	CCUPATIO	DN of work			16b. KIND OF BUS	INESS/INC	DUSTRY	White
COMPLET	Elementary/Secondary (I		College (1-4 or 5	+)	me.	gine	se retired.)	ourny mo	ist or world	ng		Chen	nical	-	
BE COI	17. FATNER'S NAME (First, M Lawrence D		nders									Houston	Surname)		
2	19a. INFORMANT'S NAME (NG ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) yford Ct. Chestertown, Md. 21620								
20 160	Daniel Saunders 14 20s. METHOD OF DISPOSITION 20b. PLACE AI				ND DATE	OF DISPOS	ITION /Na	ma of		D	ATE 20c LO	CATION —	City or Tox	wn, State	
	1 Burlei 2 A Cremetion 3 Removal from State Capital Crematory or other place Capital Crematory Jan. 2,1995 Dover, De.														
	Fellows - Wells Funeral Home 413 High St. Chestertown, Md. 21620 23 PART I. Emist by diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approxi						620								
	ahock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	nai	List only one cau	ise on ea	ach line.					Ing, suc	haac	ardiac or respi	ratory arr	rest,	Approximata Interval Between Onset and Death
NO	resulting in death) a. CARCINCOMA OF Color DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions,														
ICATIO	If any, leading to imme cause. Enter UNDERLY CAUSE (Disease or Inju	diate ING	c	(OR AS A											
CERTIFICATION	that initiated events resulting in death) LAS		DUE TO	(OR AS A	CONSEO	UENCE O	F):								
MEDICAL C	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDING ANALABLE PRIOR TO COMPLETION OF CAUSE.								AVAILABLE PRIOR TO COMPLETION OF CAUSE						
											1 TYES 2	_ 100		OF DEATH? 1 YES 2 NO	
CIAI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 No														
14SI															
ВУ Р	1 Netural 5	Pending Investigation	(Month, D	lay, Year)			URY	WO	ORY AT RK? YES 2 [NO	26d, D	ESCRIBE NOW IN	JURY OCC	CURED	
1	280 PLACE OF IN BIDY As he					ne, farm, s	dreet, facto	ory, office			281. LC	OCATION (Street a ity or Town, State)	nd Number	or Rural Re	oute Number,
S Gould not be determined 4 Homicide S Gould not be determined S Gould not be d								and menner as stated.							
BE C	29b. SIGNATURE AND TITLE	OF CERTIFIEF	1						29c. LIC	ENSE NUM	BER		29d. DATI	E SIGNED	(Month, Day, Year)
5	30. NAME AND ADDRESS OF	PERSONAMU	COMPLETED CALL	SE OF DEA	TM (ITC.	270 /5	Driet)		D-	138	2	4	> /	-1-	55
					Md.										
6	122 Speer Rd Chestertown, Md. 21620 31. DATE FILED (Mohin, Day, Hear) JAN 05'95 Julia Davidson-Randelle														



TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR	3	STATE OF MARY			MENT OF H		MENTAL HYGIEN				
1. DECEDENT'S NAME (First,	, Middle, Last)				AIL J.	DLAIII	2. DATE OF DEATH		3. TIME OF DEATH		
Anna Lou	iise Sc	ott					January 12, 1995 21:52 P.				
4. SOCIAL SECURITY NUMBER			E (In yrs. last		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.1	BIRTHPLACE (State or Foreign		
213-14-796			85	YRS.	DAYS	HOURS MIN.	May 14, 19	909	Delaware		
9a. FACILITY NAME (If not in			_	9		OR LOCATION OF D	DEATH	9c. COUNTY			
Kent and Que		es Hospita	1		Cheste	rtown		Kent			
10a. STATE	10b. COUNTY			10c. CITY, T	TOWN OR LOCAT	ION			10d. INSIDE CITY		
Maryland	Kent	t			Cheste				1 XYES 2 NO		
100. STREET AND NUMBER					10	ZIP CODE			OF WHAT COUNTRY?		
103 Lincoln Drive 21620 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No. 14. RACE - Armer)											
1 Never Married 2 Married FORCES? 1 YES 2 NO If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. MACE — Amelia If yes, specify Cuban, Maxican, Puerto Rican, etc.) 15. WES 2 NO If yes, specify Cuban, Maxican, Puerto Rican, etc.)							RACE — American Indian, Black, Whita, etc.				
3 X Widowed 4 Divo	T T		DATES		1 L TES	SW NO Sheci	rfy:		Specify: Black		
15. DEC	EDENT'S EDUCATI y highest grade con	TON Tipleted)	(Giv	ve kind of worl	WAL OCCUPATION		16b. KIND OF BU	SINESS/INDUST	RY		
Elementary/Secondary (0	⊢12) C	College (1-4 or 5+)		aborer			Food P	roducti	ion		
17. FATHER'S NAME (First, M	liridia Last)		TK	IDOLEI	C	40 MOTHER'S N					
10. MOTHER'S NAME (First, Middle, Lest) Eugene Priest Emeline Watson											
19a. INFORMANT'S NAME (Type/Print) 19b. MAJLING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							io)				
Ms. Marty Li	<u>iverly</u>						estertown,				
20g_METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c_LOCATION — City or Town State											
4 Donation 5 Other (Specify) Chesterville Forest Cemetery 01-19-95 Millington, Maryland											
22. NAME AND ADDRESS OF FACILITY Fellows Funeral Homes, P.A.											
William L			end	Ly	370 W.	Cypress S	Street, Millin	ngton, Ma			
23. PART I. Enter the di shock, or he	iseases, Dr com aert fallure. Lief	nplications that cause it only one cause on	ed the dea	th. Do not	antar the mo	de of dying, suc	ch as cardiac or resp	iratory arreat,	Approximate interval Between		
IMMEDIATE CAUSE (Fin	nal		V				4		Onset and Death		
resulting in death)	→	Carde	opul	inen	ary	arre	est.				
		OUE TO (OR AS	A CONSECU	JENCE OF):	site.	0					
Sequentially list conditi	iona, b	DUE TO (OR AS	A CONSECT	UENCE OF):	anec	wscu	roses.				
cause. Enter UNDERLYI CAUSE (Disease or Inju	ING										
that initiated events		DUE TO (OR AS	A CONSECU	UENCE OF):							
resulting in death) LAS	d										
PART II. Other significa	nt conditions c	contributing to death	but not re	aulting in i	the underlying	cause given in	Part I. 24e. WAS AN		24b. WERE AUTOPSY FINDINGS		
Q Unc.		led Dry					PERFOI	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
3 Semile	c Den	rentia &	(or	elral	Vaser	Man De	weethir in	D-110	OF DEATH?		
& Chro	mi C	corprisio	nal	Stort	e		//	7			
25. WAS CASE REFERRED TO EXAMINER?		IOSPITAL:			26. PL	ACE OF DEATH (C)	heck only one)				
1 YES 2 NO		☐ Inpatient 2 ☐ ER/Ou		DOA 4	☐ Nursing Hom		8 Other (Specify)				
27. MANNER OF DEATH 1 Natural 5	Pending	(Month, Day, Year)		28b, TIME O	Y WO	RK?	28d. OEŞCRIBE HOW I	NJURY OCCURE	10		
2 Accident Investigation 1 YES 2 NO 26s PLACE OF INJURY At home form stood feature office.											
3 Suicide 6 Could not be determined City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Stete)											
29a. CERTIFIER 1 CERT	IFYING PHYSICIAL	N- To the best of my kno	rulados des	th accurred t	- the time date	and along and du	e to the cause(a) and man				
									use(a) and manner as stated.		
296. SIGNATURE AND TITLE						29c. LICENSE NU			GNED (Month, Day, Year)		
14114	lun	no.				0213		1//	7/9 -		
30. NAME AND ADDRESS OF	PERSON WHO C	OMPLETEO CAUSE OF D	DEATH (ITEM	27) (Type, Pri				-	11/5		
KIN 1	< wa	UN, 21	6 14	rgh	54-1	Chester	lown, V	ND.	21620		
JAN 20	35	32/ REGISTEAR'S SIG	MATURE ON	della							



DHMH-16 Rev 1/89

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	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nouns at
	24
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	within
876	betno
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	REGISTRAR	YLAND / DEPARTING CERTIFIC	MENT OF HEALTH ATE OF DEAT		AL HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last) Amanda Sta	odean	NIPC	2. DAT	TE OF DEATH	Y (XEAR 2 25		
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AN		UNDER 1 YEAR IF UNDER NTHS DAYS HOURS		E OF BIRTH	/	8. BIRTHPLACE (State or Foreign Country)		
OR	PRENDS NURSING	1 (SANDY SPRING			Contract Property	TY OF DEATH		
DIRECTOR	MARYLAND MONTGOMERY		OWH OR LOCATION				10d. INSIDE CITY LIMITS?		
	10e. STREET AND NUMBER	SANDY S	10f. ZIP CODE			10g. CITIZ	1 YES 2 NO EN OF WHAT COUNTRY?		
FUNERAL	17401 NORWOOD ROAD 11. MARITAL STATUS 1. Naver Married 2 Married FORCES? 1 Y	R IN U.S. ADMED	2086	F HISPANIC ORIG	IN? (Specify Yes	-	ED STATES 14. BACE — American Indian,		
D BY F	1 Never Married 2 Merried FORCES? 1 Y IF YES, GIVE WAR OF		If yes, specify Cuber 1 TYES 2 NO		Rican, etc.)		Specify: WHITE		
ш	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	Ille. Do NOT use re	done during most of working tired.)	7	6. KIND OF BUS	INESS/INDU	STRY		
COMPLET	12 0	MUSIC BOX	ASSEMBLER 18. MOTH	ER'S NAME (First	MANUF Middle, Maiden		ING		
H	(UNKNOWN) KRETH 190. INFORMANT'S NAME (Type/Print)	19b MAH INO AD	(UNKNOWN) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
9	MARGOT H. ROBICHAUD	17812 TR	EE LAWN DR	SHTON,	MARYLAND 20861				
	1 □ Burial 2. Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify).	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify). METROPOLITAN CREMATORY 2/2 ALEXANDRIA, VIRGINIA							
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE WURIEL H. BARBER FUNERAL HOME 20882 P.O. BOX 5038 LAYTONSVILLE, MARYLAND								
	23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due to (or as a consequence of):								
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. OUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
PHYSICIAN: MEDICAL CER	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part Organic Ding ha					1 Tyes 2 No			
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Input lent 2 FB/0	EXAMINER?							
	1 Tres 2 / NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Rasidence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Nutural 5 Pending Pending 1 Nutural 1 Nutu						PRED		
	2 Accident Investigation 3 Suicide 6 Could not be determined 6 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 2 Homicide 2 Homicide 2 Homicide 2 Homicide 3 Hom						r Rural Route Number,		
		(Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(s) end manner as stated.							
BE	2 MEDICAL EXAMINER: On the basic of axamination and/or investigation, in my opinion, death occurred at the time, data and 29b. SIGNATURE AND TITLE OF CENTURE AND TITLE OF CENTURE AND TITLE OF CENTURE AND AND 29c. LICENSE NUMBER D 18726					29d. DATE SIGNED (Month, Day, Year)			
5	30. NAME AND ADDRESS OF PENSON WHO COMPLETED CAUSE OF	DEATH (ITEM 27) (Type, Prin				-	/1/95		
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SI								

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SION OF VITAL RECORDS, P.O. BOX 66/60,	TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours a
	ENDING
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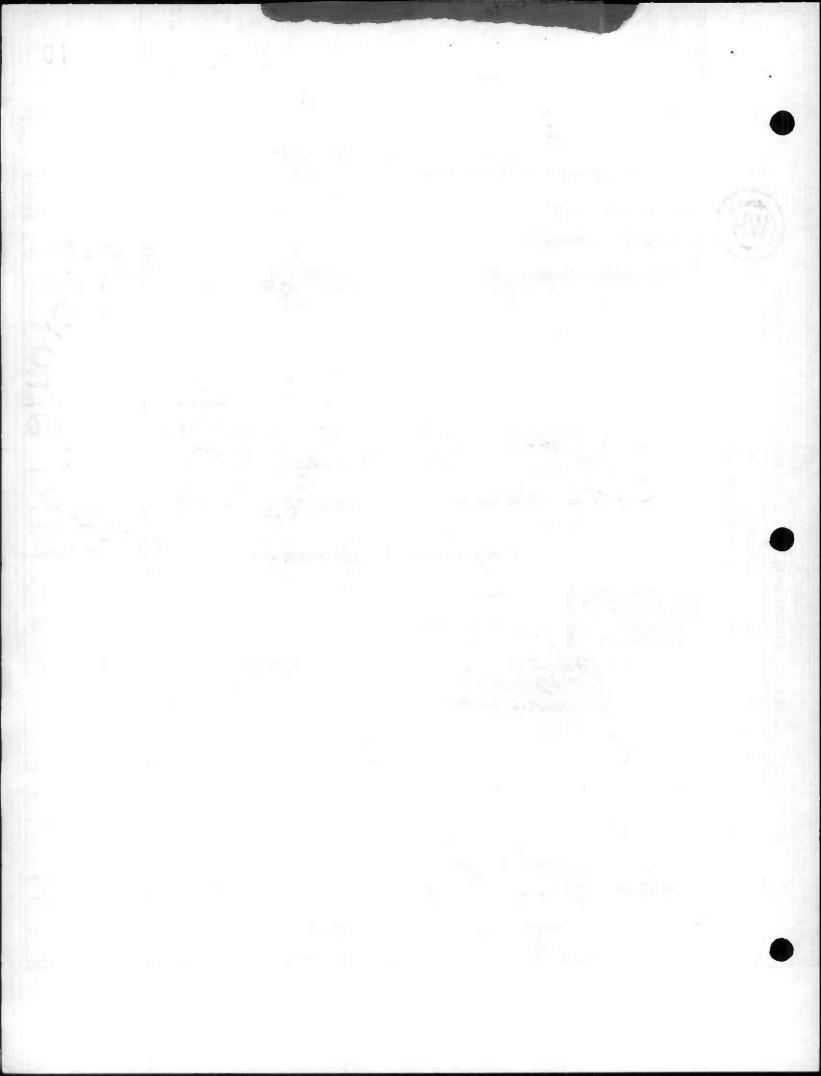
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

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TO DE CONTROL PARTIE DE CAMPA DE CAMPA	_
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FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

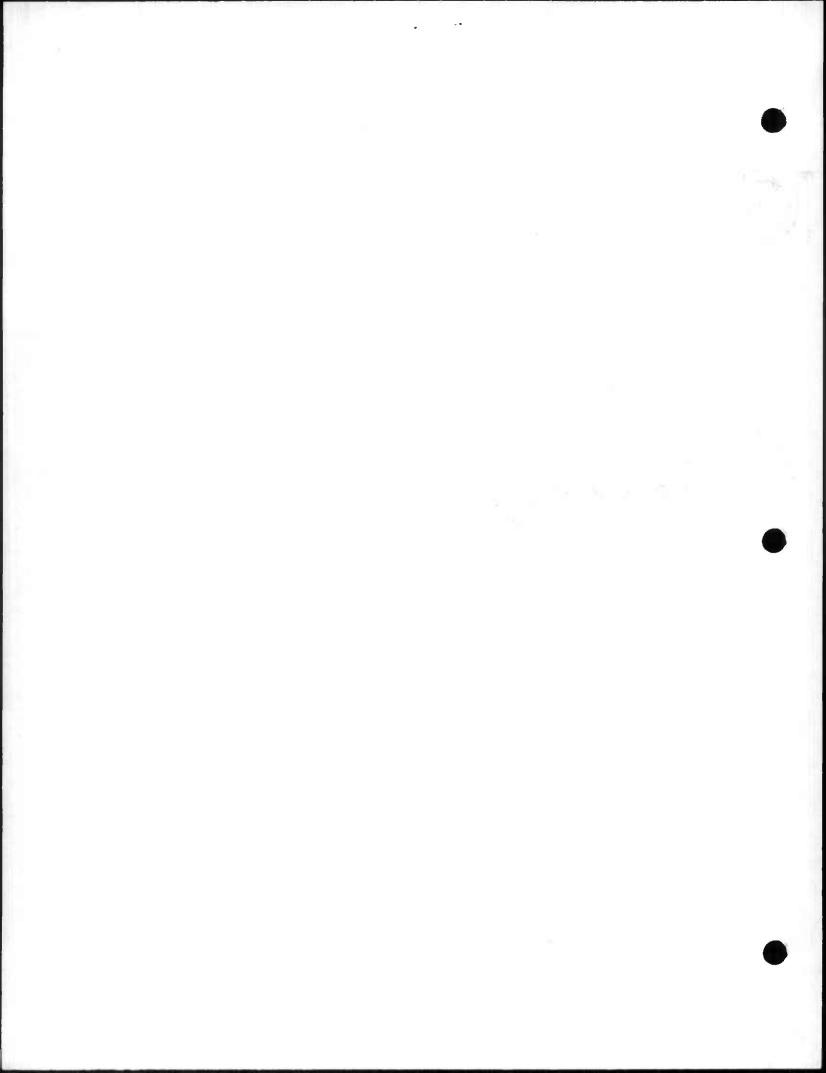
	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO.			
V	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
- 0	Lillian B.	Shorter				February 1	1995	1:30 P M	
,	4. SOCIAL SECURITY NUMBER 220-09-6616	5. SEX 6. A0	GE (In yrs. last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 4/9/1916	Coun	HPLACE (State or Foreign try) Lryland	
TOR	FACILITY NAME (If not institution, give st Alice Byrd Tawes RESIDENCE OF DECEDENT		me	96. CITY, TOWN Crisfi	e1d	EATH	Somers		
DIRECTOR	10s. STATE 10b. COUNTY Maryland Somer			rion	TION			10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	10e. STREET AND NUMBER 6333 Charles Can	non Road		10	1. ZIP CODE 21838		10g. CITIZEN OF USA	WHAT COUNTRY?	
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR OF	ES 2 NO	If yes, s	ENDENT OF HISPAI	NC ORIGIN? (Specify Yes in, Puerto Rican, etc.) y:	or No- 14. RAC Black	E — American Indian, ck, White, etc.	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5 +)	(Give kind of life. Do NOT o		ON ost of working	166. KIND OF BUS	SINESS/INDUSTRY		
\$	17. FATHER'S NAME (First, Middle, Last)		nur	se					
ŏ	Robert Greene				Lula P	ME (First, Middle, Maiden	Sumame)		
H	19a. INFORMANT'S NAME (Type/Print)		105 MAIL IN	Anness /Stmat		Route Number, City or Town	e Chate 7/a Carlo		
2	Barbara Widdowson	1				Princess .		. 21853	
	20a. METHOD OF DISPOSITION		20b. PLACE AND DATE				CATION — City or T		
	1 Burial 2 Cremation 3 Remo	oval from State	cemetery, cremetory or First Ban	other place)		2/4 Poc			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	FILSE BAD	22. NAME A	ND ADDRESS OF FA	CILITY	The state of the state of	ty, Ma.	
	D. 40	mal				1 Home, PO			
	23. PART I. Enter the diseases, or c	omplications that can	and the deeth Do	Pocom	oke City	Md. 218	51	Approximate	
	shock, or heart failure. I	a. Alg	n each line.	19 De	ment	,	01	Interval Between Onset and Death	
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING								
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):							
DICAL C	Pine	ca	not resulting in the underlying ceuse given in I			AUTOPSY 24	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE		
M	- Hugh	rollansa	3-			_	7	OF DEATH? 1 □ YES 2 □ NO	
25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check poly one)									
25. WAS CASE REFERRED TO MEDICAL 25. WAS CASE REFERRED TO MEDICAL 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Chock DN/y one) 26. PLACE OF DEATH (Chock DN/y one) 27. MANNER OF DEATH 28. DATE OF INJURY 28. THEOF 28. REJURY AT 286. DESCRIBE HOW INJURY OCCUR. (Afont). Dis., Near) 28. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Chock DN/y one) 26. PLACE OF DEATH (Chock DN/y one) 27. MANNER OF DEATH 28. DATE OF INJURY 280. INJURY AT 280. DESCRIBE HOW INJURY OCCUR. (Afont). Dis., Near)									
ву РН	27. Mannish of DEATH 1 Natural 5 Pending Accident Investigation	28s. DATE OF INJUI (Month, Day, No.	RY 286, TI	JURY W	URY AT ORKY YES 2 NO	28d. DESCRIBE HOW IN	HJURY OCCURED		
THE PLACE OF SECURITY At home from street factors office					end Number or Rural	Plaute Number			
Homicise determined building, etc. (Specify) 29a. CERTIFIER (Check only orne) Entire (Check only orne) MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a second orne.							a) and manner as stated.		
8	29b. SIGNATURE AND TITLE OF CERTIFIER	the	Loy	MIS	29c. LICENSE NUI	a/4	29d. DATE SIGNED	(Month, Day Year)	
8	30. NAME AND ADDRESS OF PERSON WHO) COMPLETEO CAUSE OF	OEATH ATEM 21) (Type	a, Print)		- /-		, , ,	
8	31. DATE FILED (Month, Day, Year) FEB 0 6 19	32. REGISTRAR'S'S	GNATURE Rand	are.					



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_	REGISTRAR		CERTIFI	CATE OF	DEATH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	Quanti.	1:27			2. DATE OF DEATH MONTH DA		VEAR	3. TIME OF DEATH
	Marvin ₩, Sweezy 本					February	1 199	95	3:15A M
	4. SOCIAL SECURITY NUMBER	S. SEX 6. AGE	SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DA			7. DATE OF BIRTH		8. BIRTH	PLACE (State or Foreign
	179-14-1173	1×2 M 2 □ F 7	'3 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) Sept 20 19	921	Peni	nsylvania
	9a. FACILITY NAME (If not institution, give at	rest and number)		96. CITY, TOWN	OR LOCATION OF DEA			NTY OF DE	
OR	Anne Arundel Medi	cal Center		Annap	olis		Anne	e Arı	unde l
ธิ	PRESIDENCE OF DECEDENT 100. STATE 101. COUNTY MD Anne Arunde I Annapolis 102. CITY, TOWN OR LOCATION Annapolis 103. STREET AND NUMBER 104. STREET AND NUMBER 105. STREET AND NUMBER 106. CITY, TOWN OR LOCATION 107. STREET AND NUMBER 108. STREET AND NUMBER 109. CITIZEN OF WHAT COUN United State 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No — 14. RACE — Americal 14. RACE — Americal 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No — 15. What is not not not not not not not not not not								
E								10d. INSIDE CITY LIMITS?	
0								1X YES 2 NO	
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Ξ								- American Indian,	
₹	1 Never Married 2 Married 2 Married 1 F YES, GIVE WAR OR DATES 1 YES 2 NO Specify: Specify: White, atc.) 1 Ves 2 No Specify: White, atc.							har.	
	15. DECEDENT'S EDUC								White
	(Specify only highest grade	completed)	16a, DECEDENT'S L (Give kind of wo life. Do NOT use	ork done during mo	on ost of working	16b. KIND OF BUS	SINESS/IND	USTRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ministe	,		Cler	· au		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		14111110	-	40 MOTHERIO MAN	E (First, Middle, Maiden			
	Marvin J. Sweezy	,			1211	E. Walter			
8	19a. INFORMANT'S NAME (Type/Print)		19h MAII ING	ADDRESS /Street	L.	oute Number, City or Town		0.41	
2	Sarah B. Sweezy					napolis, N			21401
	29a METHOD OF DISPOSITION	20h	PLACE AND DATE OF				CATION —		
	1 Buriel 2 Cremation 3 Remo	oval from State	ary crematory or oth	veteran	Cemetery	2/6/95	rown	evil	IA MD
	1. Burlat 2 Cremation 3 Removal from State Camplery, crematory or other place) Camplery								inoral Homo
	Harrie Market	TH.		147 [uke of G	loucester	S+	Annar	olie MD
	22 PART I Spier the diseases	Juj IN							0113, ND
	23. PART I. Enter the diseeses, or c shock, or heart failure. I	lat only one cause on a	i the death. Do no ach line.	ot enter the mo	da of dying, auch	as cerdiec or reapi	ratory arr	est,	Approximata interval Between
	IMMEDIATE CAUSE (Fine)							Onset and Death	
	resulting in death)	· KOD +	CONSEQUENCE OF						,
_		CHE	CONSEQUENCE OF)	:					2
CERTIFICATION	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):							*	
¥ I	if sny, leading to immediate cause. Enter UNDERLYING	Casa (2.1. 4	m) -					2
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	:					-
E	resulting in death) LAST	L							
	BADT II Other clerifficant and finite								
MEDICAL	PART II. Other significent conditions	f)		the underlying	ceuse given in P	art I. 24a, WAS AN A PERFOR			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	awail	+15/11/ah	<u>~</u>			1 - YES 2	X NO		COMPLETION OF CAUSE OF DEATH?
×						_			1 U YES 2 NO
Z	DID TOBACCO USE CONTR				UNCERTAIN			\perp	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	OTHER:					
± ₹	1 YES 2X NO 27. MANNER OF DEATH	1 Inputient 2 ER/Outp. 28a. DATE OF INJURY				Other (Specify)			
	1 Netural 5 Pending	(Month, Day Year)	28b. TIME INJU	RY WO	RK(A // Li	28d. DESCRIBE HOW IN	JURY OCC	URED	
B	2 Accident Investigation	28a PLACE OF INHURY	N hama iam		17/	IUA			
3 Suicida 8 Could not be detarmined 28s. PLACE OF INJURY — At home, tarm, street, factory, offica building, etc. (Specify) 28s. PLACE OF INJURY — At home, tarm, street, factory, offica building, etc. (Specify) 28s. LOCATION (Street and Number or Runfil Route Number, City or Town, State)							oute Number,		
29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as esisted.									
2 MEDICAL EXAMINER: On the beals of axamination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner as stated						and manner as stated.			
8	196. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Morith, Day, Year)								
P P	W. lul Cl.				D33099		▶Fel	oruar	ry 1, 1995
-	30. NAME AND ADDRESS OF PERSON WHO								
	Richard A. Berns			ey Avenu	e Annapol	lis, MD 21	401	(410-	-266-1644)
	31. DATE FILED (Month, Dey, Year) 1995	32 AEGISTRAR'S SIGNI	TURE						
		HILLA OU WILLIAM	rvardall						- 1



FOR

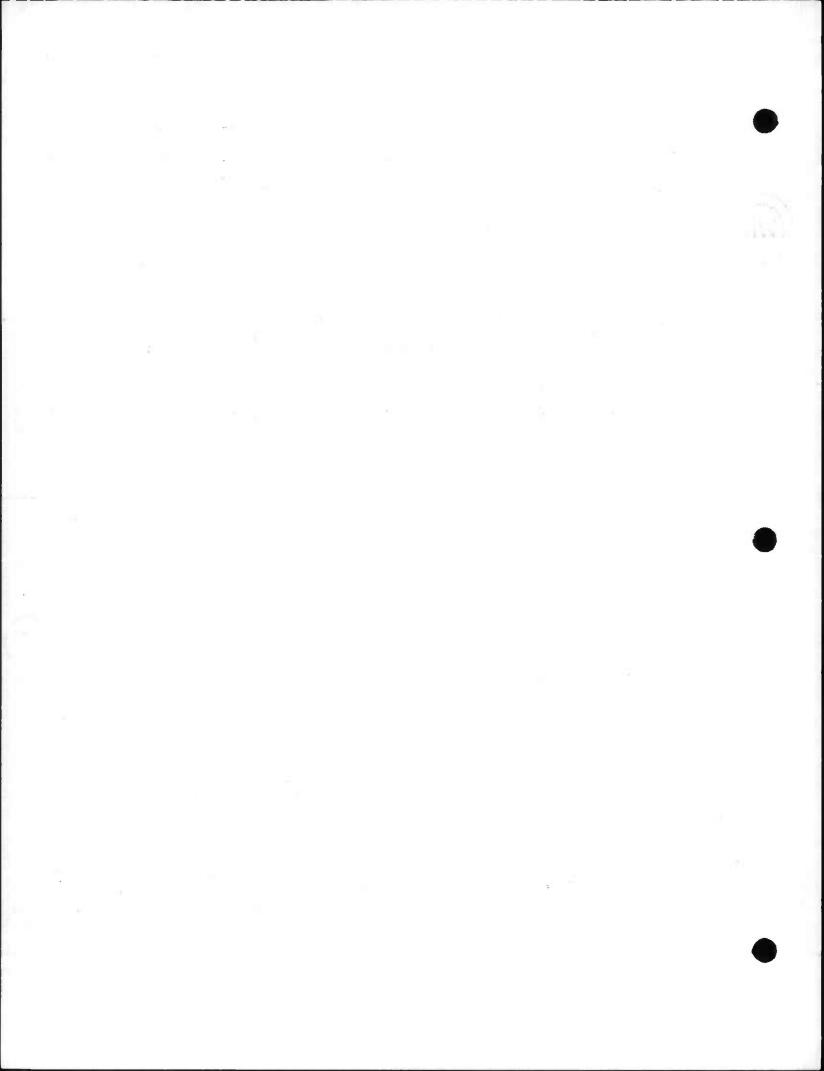
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CERTIFIC	ATE O	FDEATH	REG. NO).						
	1. OECEOENT'S NAME (First, Middle, Last)				2. DATE OF OEATH			3. TIME OF OEATH				
- 1	Rose A. Smith				Feb. 7,	199	5 YEAR	7:30P M				
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In		UNDER 1 YEAR		7 DATE OF BIRTH		8. BIRTN	PLACE (State or Foreign				
	579-12-1316 1□M2△F 8	7 YRS.	THS DAYS	HOURS MIN.	March 3,	1907	Per	nsylvania				
	9s. FACILITY NAME (If not institution, give street and number)	9b.	CITY, TOW	OR LOCATION OF D			NTY OF D					
DIRECTOR	Kensington Gardens Nursi	ng Home		Kensin	gton		Mont	gomery				
Ä	10e. STATE 10b. COUNTY	10c. CITY, TO						10d. INSIDE CITY				
ā	Maryland Montgomery	Roc	kvi1	1e				TE YES 2 NO				
AL.	10e. STREET AND NUMBER			IOI. ZIP CODE		10g. CIT	ZEN OF W	HAT COUNTRY?				
FUNERAL	14639 Bauer Drive - #20	7		208	53	A	meri	can				
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS D	ECENDENT OF NISPA	NIC ORIGIN? (Specify Y	s or No-	14. RACE	— American Indian,				
ВУ	1 Never Married 2 Married FORCES? 1 YES IF YES, GIVE WAR OR DATE			ES 2 NO Speci	an, Puarto Rican, etc.) fy:			y: White, etc.				
COMPLETED	15. OECEDENT'S EDUCATION (Specify only highest grade completed)	18a. DECEDENT'S USU	AL OCCUPA	TION	16b. KINO OF BI	JSINESS/INC	DUSTRY					
Щ	Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of work life. Do NOT use ret	ired.)	nost of working		_						
J P	7	Waitres	ន		Food	Ser	Vice	9				
Ö	17. FATNER'S NAME (First, Middle, Last)			18. MOTNER'S NA	AME (First, Middle, Maide	Surname)						
BE (Peter Arbushitis			Agne	s Scherc	alli	ous					
5	19a, INFORMANT'S NAME (Type/Print)				Route Number, City or To			20872 Maryland				
F	Alton L. Smith, Jr.	26619	Cla	rksburg	Road, D	amas	cus,	Maryland				
		PLACEAND DATE OF DI lety, crematory or other to NTGOMETY			m 2/9 Be	thes	city or Ton	wn, State Maryland				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
Ì	Mount & William	N						neral Home				
	23. PART i. Enter the diseases, or complications that caused	the death De not a	2640	1 Ridge	Road, D	amas	cus,	Maryland				
	ahock, or haert failure. List only one ceuse on ae	ch line.		_		-	reat,	Approximata Interval Batween				
ĺ	Interval Datagell											
	IMMEDIATE CAUSE (Final disease or condition reaulting in death) Oneet and Death Oneet and Death Oneet and Death Oneet and Death											
_	DUE TO (OR AS A C	CONSEQUENCE OF):										
CERTIFICATION	Sequentially list conditions, OUE TO (OR AS A C	CONSEQUENCE OF):										
¥	cause. Enter UNDERLYING	2000						į l				
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듄	resulting In death) LAST											
	PART II Other classificant and distance and final and and the											
DICAL	PART II. Other algnificent conditions contributing to death bu	t not reaulting in th	e underlyl	ng cause given in	Part I. 24s. WAS A		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO				
ă	OSTEO POPOSIS	1			1 YES	2 XNO		COMPLETION OF CAUSE DF DEATH?				
Æ	Congestion beaut For							1 TES 2 NO				
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	DEATH YES	Z NO	☐ UNCERTAI	N 🗆							
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HIOSPITAL:	8. PLACE OF OEATH (C	-	9)								
PHYSICIAN:	1 YES NO 1 Inpatient 2 ER/Outpat	tlent 3 DOA 4	HER: Nursing No	me 5 🗆 Rasidence	6 Other (Specify)							
표	27. MANNER OF OEATN 28s. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY		JURY AT ORK?	28d. DESCRIBE HOW	INJURY OC	CUREO					
B	Natural 5 Pending Investigation			YES 2 NO								
	3 Suicide 6 Could not be 28a. PLACE OF INJURY - building, atc. (Specifi	At home, farm, street	, factory, off	Ice	261. LOCATION (Street City or Town, State		or Rural R	oute Number,				
	4 Homicide datarmined											
COMPLETED	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge)	dge, death occurred at	the time, de	te and piece, and due	to the cause(a) and ma	nner se stat	ed.					
8	one) 2 MEDICAL EXAMINER: On the besis of examination	and/or investigation, in	my opinion,	death occured at the	time, data and place, a	nd due to th	e cause(s)	and manner as stated.				
	29b. SIGNATURE AND TITLE OF CERTIFIER			29C, LICENSE NU	MBER	29d. DAT	E SIGNED	(Month, Day, Year)				
) BE	Value			D34	045	▶Fe		3, 1995				
임	30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF CEAT			1	J / J							
	Philip G. Henjum, M.D	13975 Cc	nnec	ticut A	ve., Sil	ver	Spr	ing, Maryla:				
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNAT	TURE										
	FFB 1 0 1995	4-Randall						- I				

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a choice after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-frame be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 687604

OHMH-18 Rev 1/89



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Siggin 995 MId an 10:50 A SOCIAL SECURITY NUM 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 XM 2 - F 84 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 5512 C DIRECTOR e 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY UMITS? Maryland 1 YES 2 NO FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? use as the burial-transit 1701 retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married
3 Wildowed 4 Divorced If yes, specify Cuben, Maxicen, Puerto Rican, etc.)

1 YES 2 NO Specify: BY White COMPLETED 18s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life, Do NOT use relired.) 15. DECEDENT'S EDUCATION early only highest grade complet 16b. KIND OF BUSINESS/INDUSTRY (Spe be detached for ndary (0-12) College (1-4 or 5+) Supervisor chaincerin 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden S Hrchi Ħ BE funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print, MAILING ADDRESS (Street and Number 2 Patricia 8 aprile must be 20a. METHOD OF DISPOSITION

1

Spurial 2 Cremation 3

Removal from State PLACE AND DATE OF DISPOSITION (Name of urs after death. Page 6 may 20c. LOCATION - City or Town, State SEE. 4 Donation 5 Other (Specify) emeter 21. SIGNATURE OF FUNERAL SERVICE LICENSEE the medical examiner 22. NAME AND ADDRESS OF FACILITY wheral Home 1621 hossumtown Frederick 23. PART I. Enter the diseases, or complications that clusted the desth. Do not enter the mode of dying, such as cardiec or respiratory street, shock, or heart fellure. List only one cause as each line. MD illed in by the removal Approximate Interval Batween cremation, or IMMEDIATE CAUSE (Final **Onset and Death** of the lune disease or condition DUE TO (OR AS A CONSEQUENCE OF): attending physician and completely ental Hydiene prior to burlal, cremati resulting in death) event, DIVISION OF VITAL RECORDS, P.O. BOX 68760, requires that the death certificate be executed with other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 Mental ! injury, n signed by the a f Health and Men PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any 1 TYES 24 NO OF DEATH? Shows 1 YES 2 NO this certificate has been with the State Dept. of PHYSICIAN: HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 TYES 2 THO 1 Inpetient 2 ER/Outpetient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 6 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE NOW INJURY OCCURED marked, 1 - Natural 5 Pending Investigation 1 TES 2 NO DIRECTOR; After the hours after death was BY 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 90 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 28 4 Homicide Item 29a. CERTIFIER
1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) FUNERAL within 72 h MPORTANT: If 2 MEDICAL EXAMINER: On the basis of examination and/or I ath occured at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF 29d. DATE SIGNED (Month. 29c LICENSE NUMBER 8 THE THE ans 223 2

31. DATE FILED (Month, Day,

201 10 a

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

Spec#White

1 YES 2 NO

Approximata

interval Between

Onset and Death

27day

25 days

24 days

24b. WERE AUTOPSY FINOINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

February 7. 1995

3 Maryland

United States

Talbot

12:30

2. DATE OF DEATH

7. DATE OF BIRTH AUGUST 12,

1995

Feb.

Nathaniel

9a. FACILITY NAME (If not institution, give street and number,

4. SOCIAL SECURITY NUMBER

216 18 5328

Ali 31. DATE FILED (Month, Day, Year)

FEB 08

Dare

1 XM 2 | F

8. AGE (In yrs. last birthday)

YPS

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DAYS

IF UNDER 1 YEAR IF UNDER 24 HRS.

HOURS

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the hospital or attending physicis detached for use as the burial-t BALTIMORE, MARYLAND 21215-0020 after death. Page 6 may be retained by the hospital or attending in the funeral director, page 5 should be detached for use as the Ħ 黑 must filled in by the figor, or removal. medical signed by the attending physician and completely fill Health and Mental Hygiene prior to burial, cremation, the event. executed with other traumatic shows any injury, r this certificate has been so the with the State Dept. of Hi arked, or item 23 show HOSPITAL OR ATTENDING PHYSICIAN: After 50 DIRECTOR: A hours after c FUNERAL WITHIN 72 h MPORTANT TO THE P

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

notified

examiner

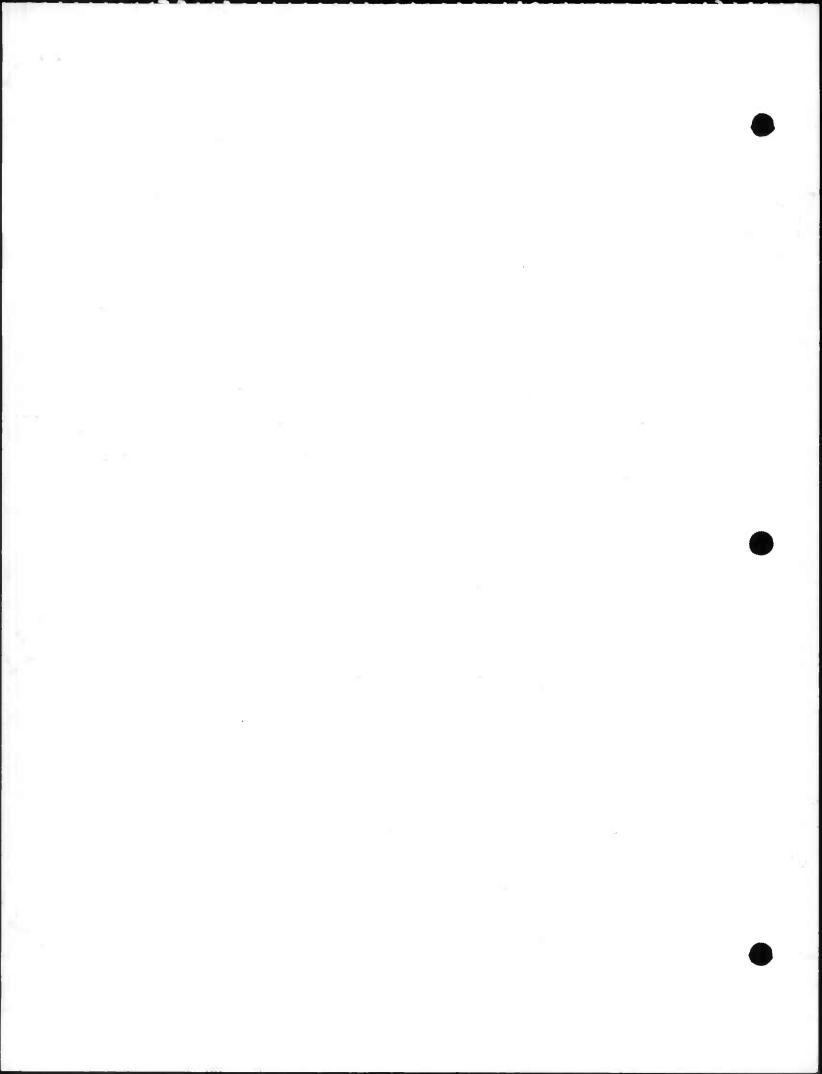
9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Easton Memroial Hospital Easton DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Kent Chestertown 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Box 4 Waters Street 21620 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES It yea, specify Cuban, Maxican, Puarto Rican, atc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EQUCATION 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INOUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) farmer agriculture 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Nathaniel Dare Sollers III Virginia McCullough 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel M. Sollers 1095 Sollers Wharf Road Lusby, Maryland 20657 20s. METHOD OF DISPOSITION
1 X Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State MiddleHam ChapelFebruary 10,1995 Lusby Calvert Maryland 4 Donation 5 Other (Specify) 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home 21. SIGNATURE OF FUNERAL SELEVICE LICENSEE 4405 Broomes Is. Rd. Port Republic Maryland 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line IMMEDIATE CAUSE (Final disease or condition resulting in death) erebrovascular accident with left hemyplefia CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING OUE TO (OR AS A CONSEQUENCE OF): menuouites CAUSE (Disease or injury that initiated eventa resulting in death) LAST Premionites PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY Hyperteusion with end state rend destare 1 YES 2 KNO aneura chrouic disease DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER: 1 YES 2 1 NO 1 Kinpstient 2 - ER/Outpatient 3 - DOA 4 - Nursing Homa 5 - Rasidence 8 - Other (Specify) 27. MANNER OF DEATH 28a. OATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 🔀 Natural 5 Pending м 1 YES 2 NO BY 2 Accident Investigation 28s. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER 1 🖔 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 _ MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 528ha M D 46020 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

506 Idlewild Ave. Easton Maryland 21601

32. REGISTRAR'S SIGNATURE

DHMH-18 Rev 1/89



OHMH-18 Rev 1/89

REG. NO

DIRECTOR

FUNERAL

BY

COMPLETED

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and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit o burial, cremation, or removal. retained by the hospital or attending physician. Once. To notified Page 6 may be Pe must examiner hours after death. medical the event, traumatic attending physician a other t 6 the atten any Injury, signed by t Health and has been Dept. of h The certificate h Item ATTENDING PHYSICIAN: 6 the this c marked, After 1 60 DIRECTOR: / 28 OR. FUNERAL I within 72 h

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

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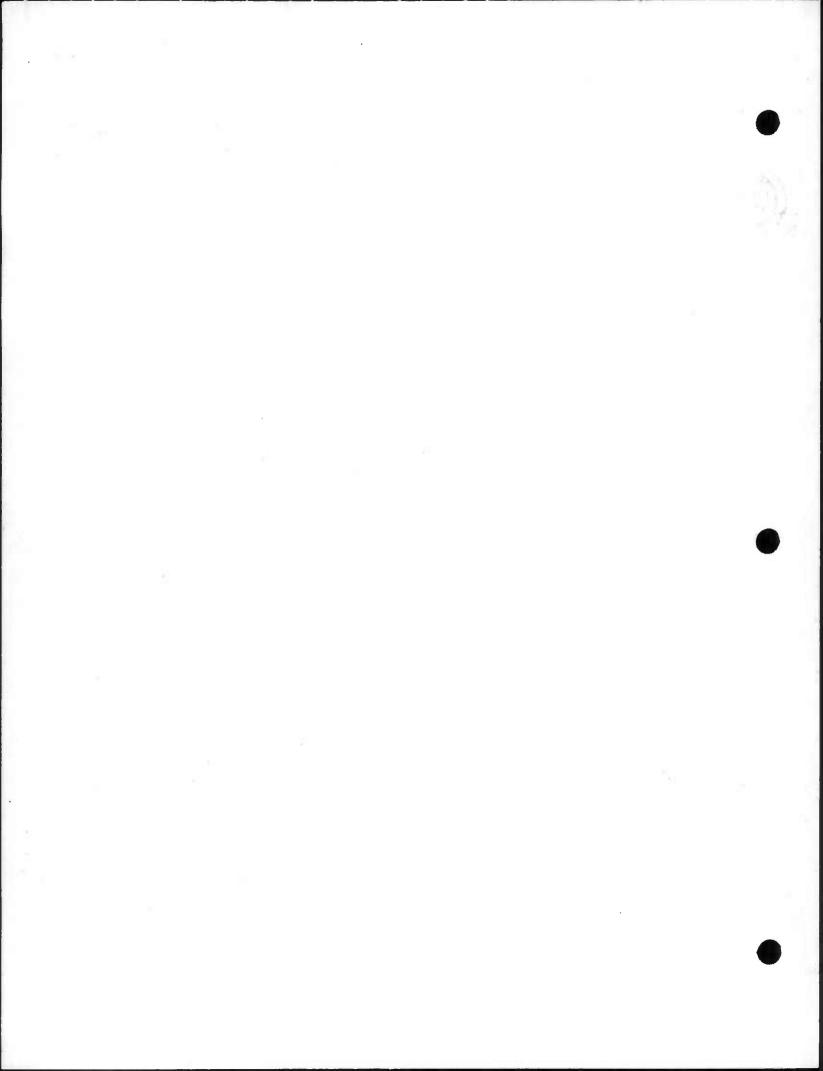
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL TO THE HOSPITA
TO THE FUNERA
DE filed within 72
IMPORTANT: II

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 EAR NATHAN ISRAEL SHAPIRO JANUARY 28", 9:35 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH JE UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MARCH 15, 1908 577-28-4645 NEW JERSEY 1 X M 2 F 86 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 14510 HOMECREST ROAD MONTGOMERY SILVER SPRING RESIDENCE OF DECEDENT INC. CITY TOWN OR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY SILVER SPRING 1 YES 24 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 14510 HOMECREST ROAD 20906 UNITED STATES 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerlo Rican, atc.)

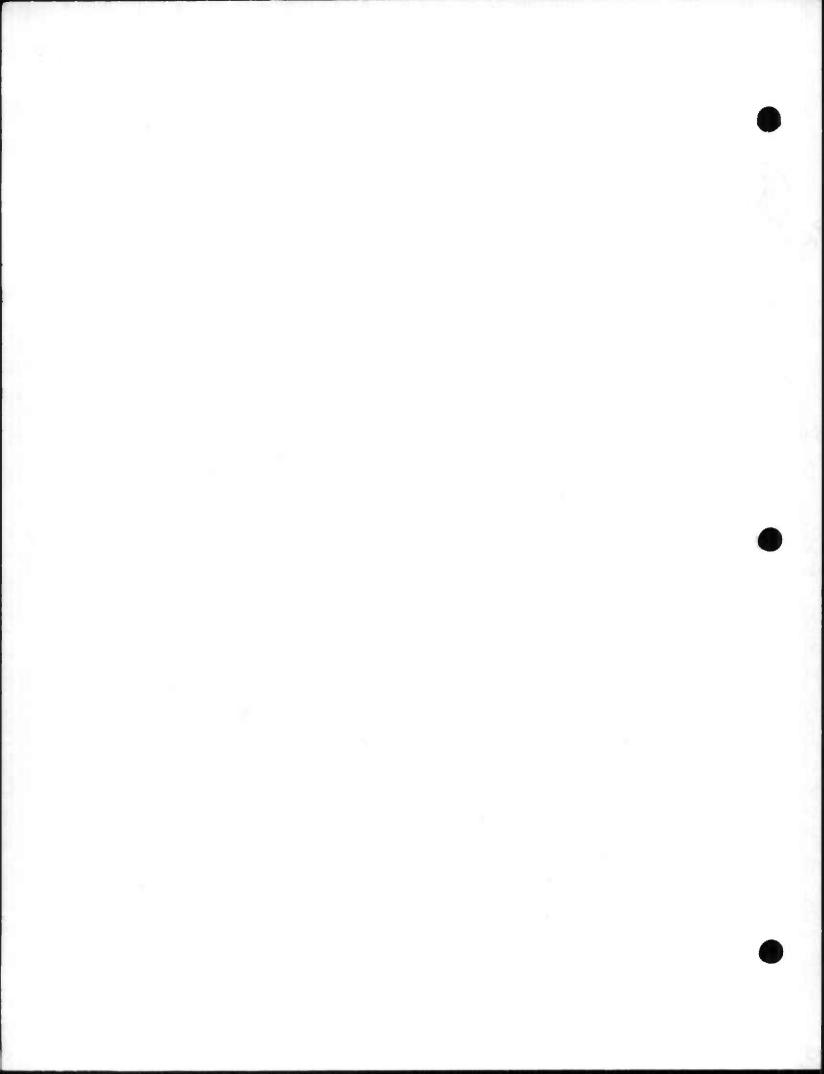
1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, OIVE WAR OR DATES 1923 3 X Widowed 4 Divorced WHITE 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) 6 OWNER RETAIL MENS WEAR 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ISRAEL SHAPIRO MANYA BRODSKY 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRWIN SHAPIRO (SON) RFD #2 BOX 238 - WOODSVILLE, NEW HAMPSHIRE 03785 20e METHOD OF DISPOSITION
1 ABurlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State MI. LEBANON CEMETERY 4 Donation 8 Other (Specify) 1/29 ADELPHI, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE.MD.20852 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reepiratory arrest, Approximate ahock, or heart fellure. List only one cause on each line. Intervel Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition resulting in death) mme ofic cardiovasulas disease Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events reaulting in death) LAST PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 - YES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO K UNCERTAIN I 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 1 | Inpatient 2 | ER/Oulpatient 3 | DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 K Natural 5 Pending 1 YES 2 NO Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, lactory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 | Homicide 29a. CERTIFIER 1 CERTIFYINO PHYSICIAN: To like beat of my knowledge, death occurred at the time, data and place, and due to the cause(s) end manner as stated. 2 MEDICAL EXAMINER. On the basis of examination and/or investigation, in my opinion, death occurred at the lime, data and place, and due to the ceuse(s) and manner as stated 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) 128. PO1120 JAN 1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WALTER E. GOOZH, MD - 2309 SHOREFIELD ROAD - WHEATON, MARYLAND 20902 32. REGISTRAR'S SIGNATURE 31. DATE FILEO (Month, Day, Year) Davidson Reveall 30 1995



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	1 - FOR STATE REGISTRAR	STATE OF M		DEPAR					MENT		_		
	1. DECEDENT'S NAME (First, Middle, Last)				10/51.		DLA	111		REG. NO.			3. TIME OF DEATH
	Verda R.	Sanc	hez						MOR			YEAR 5	1:30 A ^M
			8. AGE (In yrs. las	t birthday)	IF UNDER		IF UNDER	24 HRS.	7 DAT	E OF BUTTU		B. BIRTH	PLACE (State or Foreign
	253-22-8765	1 M 2 X F	86	YRS.	MONTHS	DAYS	HOURS	MM.	Nov	nth, Day, Year) Country)			
3	9a. FACILITY NAME (If not institution, give street				9b. CITY	, TOWN O	R LOCATIO	ON OF OR			9c. COUNTY OF DEATH		
O.	Presidential Woods	Nursing	Home		Ade.	lphi				Prince Georges			
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			10c CIT	V TOWN	OR LOCAT	1011						
DIRECTOR		Georges		10c. CITY, TOWN OR LOCATION Adelphi						LIMITS?			10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	0001800		220	Terbi		ZIP CODE	F			10= CITIZ	EN OF V	1 🔀 YES 2 🗌 NO
ER	1803 Elton Road						2078				11.5	SA	MAI COONTAT?
FUNERAL	11. MARITAL STATUS	2. WAS DECEDENT	EVER IN U.S. AR	MED	13.	WAS DECI			IIC ORIG	IN? (Specify Yea			— American Indian,
BY F	1 Never Married 2 Married	FORCES? 1	YES 2 NR OR DATES	10		If yes, spe	2 X NO	n, Mexica	n, Puerte	Rican, etc.)		Spec/	, White, etc.
	3 ☑ Widowed 4 □ Divorced										1		White
핃	15. DECEDENT'S EDUCAT (Specify only highest grade co.		(Gi	CEDENT'S	vork done	CCUPATIO	N at of workin	ng	10	66. KIND OF BUS	INESS/INDU	STRY	
岁	Elementary/Secondary (0-12)	College (1-4 or 5+)		Seams						C1 - +1-			
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)			Seams	LIES	75	40 11071	AFFOR MAN	NE 051	Cloth:	-		
Ö	William Roberson									tberry	Sumame)		
BE	19a. INFORMANT'S NAME (Type/Print)		198	. MAILING	ADDRESS	(Street ac				mber, City or Town	State Zio (ode)	
유	Joyce B. Huber									Mary1a		2078	3
	20a, METHOD OF DISPOSITION 1 A Burlel 2 Cremetion 3 Remove	14	20b. PLACE A	AND DATE	OF DISPOS	ITION (Nac	me of		D.A	TE 200 LOG	CATION - C	ty or To	wn State
	4 Donation 5 Committee (Specify)	II from State	Spring Spring	Grove	Free	Will B	ap.Ch	ı.Cem	2/	2 Jesu	p, Ge	org	ia
1	21. SIGNATURE OF FORERAL SERVICE LICENSEE / 22. NAME AND ADDRESS OF FACILITY HINES-Rinaldi Funeral Hom										neral Home		
	11800 New Hampshire Avenue Silver Spring, Maryland 20904												
	23. PART I. Enter the diseases, or con	inplications thet	caused the de	ath. Do r	ot enter	the mod	de of dyl	ng, suci	as ca	rdiac or respin	ratory arre	Bt,	Approximate
	shock, or heart fallure. List only one ceuse on each line. IMMEDIATE CAUSE (Fine) disease or condition												
	IMMEDIATE CAUSE (Fine) disease or condition resulting in death) a. Cardeae arms a. Cardeae arms a. Cardeae											ummed	
	Sequentielly list conditions, if any, leading to immediate Cardere avvis a. Cardere avvis Due to (or as a consequence of): Oriset and Daath Minimediate Oriset and Daath Minimediate Oriset and Daath Ori												
NO I	Sequentielly list conditions, as a consequence conditions and consequence conditions.												
E	if any, leading to immediate cause. Enter UNDERLYING	1/ /	- TI	OENCE OF	1:	de	seo		7				
윤	CAUSE (Disease or Injury that initiated events	A CONTROL	OR AS A CONSEQ	WENCE OF):								
CERTIFICATION	resulting in death) LAST												
	PART II. Other algnificant conditions of	andelbuden to d										_	
PHYSICIAN: MEDICAL	TANT II. Other algumeant conditions of	ontributing to o	eeth but not re	esulting I	n the un	derlying	ceuse g	iven in	Part I.	24a. WAS AN A PERFOR	MED?	246.	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
										1 TYES 2	NO		OF DEATH?
Σ	DID TOBACCO USE CONTRIE	RUTE TO CAL	ISE OF DEAT	TU VE	сПь	10 [LINIC	FDTAIN	. 10/				1 YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL	JOIL TO CAU		E OF DEAT			UNC	ERTAIN		Ļ		1	
Sic		OSPITAL:			OTHER	1:		aldamaa		er (Specify)			
¥	27. MANNER OF DEATH	28e. DATE OF IN	JURY	26b. TIM	E OF	28c. INJU	IRY AT	sidence		SCRIBE HOW IN	JURY OCCU	RED	
ВУР	Natural 5 Pending Investigation	(Month, Day,	708r)	INJ	URY M	1 Y	RK? ES 2 [NO					
	3 Suicide 6 Could not be	28e. PLACE OF building, et	INJURY — At hor	me, farm, s	treet, facto	ory, office			28f. LO	CATION (Street as	nd Number or	Rural R	oute Number,
COMPLETED	4 Homicide determined								Cit	y or Town, State)			
7	29a. CERTIFIER (Check only) 1 CERTIFYING PHYSICIA	N: To the best of m	y knowledge, dea	rth occurre	d at the ti	me, data a	and place,	and due	to the co	use(a) and man	ner as stated		
ON	one) 2 MEDICAL EXAMINER: (On the beals of exa	minetion and/or in	nvestigation	h my o	pinion, de	ath occur	ed at the t	ilme, dat	e and place, and	due to the	cause(a)	and manner as stated.
ш	200. SIGNATURE AND STILE OF CENTRUM	0	1	0	1	11.	29c. LICE	NSE NUM	BER	. 1	29d. DATE S	SIGNEO	(Month, Day, Year)
TO B	-Wall		1	X.	M	1	P	011	2		► J1.	W	30 1995
F	30. NAME AND ADDRESS OF PERSON WHO C												
	Walter E. Goozh, M.			ield	Road	, Wh	eato	n, M	lary	land 2	20902		
	31. DATE FILED (Month, Day, Year)	Julia Da	S SIGNATURE	1 11								_	
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ZA hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

												3) (1401
	1 - FOR STATE REGISTRAR	,	STATE OF N	IARYLAND	/ DEPAR	TMEN ICAT	T OF H E OF	EALTH DEAT	AND I	MENT	AL HYGIEN REG. NO	E		
3	1. DECEDENT'S NAME (First, Middle	e, Last)								2. DAT	E OF DEATH		YEAR 3	. TIME OF DEATH
		M S	kelley								eb 4	"199		8:12AM M
	4. SOCIAL SECURITY NUMBER	5.	. SEX	6. AGE (In yrs.	last birthday)		R 1 YEAR	IF UNDER	24 HRS.	7. DAT	E OF BIRTH			
	218-48-9782	7	V M 2 □ F	48	3 YRS.	MONTHS	DAYS	HOURS	MIN.		e BIRTH (State or Foreign nth, Day, Year) 10. BIRTHPLACE (State or Foreign Country) MD			
	Se. FACILITY NAME (If not institution	n, give street	end number)			9b. CIT	Y, TOWN (R LOCATION	ON OF DE		IIC IO		NTY OF DEA	
E E	Memorial	Hos	spital								7	11		
Ĕ	RESIDENCE OF DECEDER	NT	- Julian		Cumberland							A	lleg	any
DIRECTOR		county 11ega	iny			y, town	or Locat Land	ION						Dd. INSIDE CITY LIMITS? YES 2 NO
A	10s. STREET AND NUMBER			101	. ZIP CODI				10g. CITI		AT COUNTRY?			
FUNERAL	423 Grand Aver	nue					2	1502				USA	L.	
3	11. MARITAL STATUS	12	. WAS DECEDEN	T EVER IN U.S.	ARMED	13.	WAS DEC	ENDENT O	F HISPAN	IIC OBIG	IN? (Specify Yes	or No I	14 PACE	American Indian
	1 Never Merried 2 Married FORCES? 2 YES 2 IF YES, GIVE WAR OR DATES				NO		If yes, sp-	ecity Cube	n, Mexica	n, Puerto	Rican, etc.)	U 110-		- American Indian, White, atc.
BY	3 ☐ Widowed 4 ☐ Divorced IF YES, GIVE WAR OR DATES VIETNAM						1 YES	2 NO	Specify	<i>(</i> :		1	Specify: Wh	ite
8	15. DECEDENT	'S EDUCATI	ION	16a.	DECEDENT'S	USUAL C	CCUPATIO	ON .		16	b. KINO OF BUS	INESS/IND	USTRY	
ы	(Specify only highes		npleted) College (1-4 or 5 +		(Give kind of life. Do NOT u	work done se retired.)	during mo	st of workin	g					
릴	Elementary/Secondary (0-12)				irema	n					City o	of Cu	mberl	and
COMPLETED	17. FATHER'S NAME (First, Middle, Le	ast)						18. MOTH	IER'S NAI	ME (First,	Middle, Maiden	Surname)	_	
<u>ы</u>	William Mic	hael	Skelley	Y				Ka	athei	rine	Kinsm	an		
BE	19a. INFORMANT'S NAME (Type/Print	nt)			19b. MAILING	ADDRES	S (Street a	nd Number	or Rumi F	Pourte Nuc	nher City or Tow	State Zin	Codel	
임	198. INFORMANT'S NAME (Type/Print) 199. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)													
	10s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State													
	Sunset Memorial Park 02/07 Cuttber (and, MID)													
- i														
	Junes		MCC	MPI	M						1502			
	23. PART / Entar the disease shock, or heart fs	a, or com	pilications that	caused the	desth. Do i	not antai	r tha mo	da of dyi	ng, suct	aa ca	diac or respi	ratory arr	eat,	Approximate
	IMMEDIATE CAUSE (Final		only one cou	oa on escii iii	ire.									Interval Between Onset and Death
- 1	disease or condition		Huner	tonci	110 0	224				1-				vrs
	resulting in death) a. Hypertensive cardiovascular heart disease yrs one to (or as a consequence of):													
z		b .												
ERTIFICATION	Sequentially list conditions, if any, lasding to immediate		OUE TO	OR AS A CONS	EOUENCE O	F):								
S	cause. Enter UNDERLYING CAUSE (Disease or injury	.												
E	that initiated evanta	1	OUE TO	OR AS A CONS	EOUENCE O	F):								
E	resulting in death) LAST													
0	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY FINDINGS													
S	William anglithodate out	iditions c	onthouting to	uaatii but ilo	readiting	iii tha ui	nueriying	cause g	iven in i	Part I.	24a. WAS AN PERFOR		AV	ERE AUTOPSY FINDINGS MILABLE PRIOR TO
ă											1 - YES 2	0		OMPLETION OF CAUSE F DEATH?
Z I													1	YES 2 NO
ä	DID TOBACCO USE CO	ONTRIB	UTE TO CAL	USE OF DE	ATH YE	S 🗆	NO [UNC	ERTAIN	1/2				
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDIO EXAMINER?	1	OSPITAL:	26. PL	ACE OF OEA									
Š	YES 2 NO			ER/Outpatient	3 DOA	OTHE		5 🗆 Re	aldenca	6 🗆 Oth	er (Specify)			
동비	27. MANNER OF OEATH		26e. OATE OF (Month, De		28b. TIM	E OF URY	28c, INJI WO			28d. OE	SCRIBE HOW II	JURY OCC	UREO	
BY	1 Natural 5 Pending 2 Accident Investig		1	y, roury	- "	M	1 🗌 Y		NO					
	3 Suicide 8 Could n		28e. PLACE OF	INJURY — At I	nome, ferm,	treet, fec	tory, office	,			CATION (Street a	nd Number	or Rural Roul	te Number,
밀	4 Homicide datermin		bulliang, i	ntc. (Specify)					- 1	City	or Town, State)			
COMPLET	29e. CERTIFIER 1 CERTIFYING	PHYSICIAN	N: To the heat of	my knowledge	death accord	of go al-	lime des	and at-		10.45	wastet == 1			
M	296. CERTIFIEN (Check only (Check only Additional Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only Additional Check only (Check only Additional Check only (Check only Additional Check only (Check only Additional Check only (Check only Additional Check only (Ch													
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BE	296 STONATORE AND TITLE OF	MINIEM				2.0		29c. LICE				29d. DATE	SIGNEO (M	onth, Day, Year)
2	30. NAME PAOORESS OF PERSO	041 14110 00	ALIOI ETEO 6		Opty	Med	l Ex	D	091	57			Feb	4, 1995

Snow, Paul M.D. 31. DATE FILED (Month, Day, Year) FEB 07

123 W 3rd st Cumb Md 21502 32. REGISTRAS SIGNATURE

Dpty Med Ex

DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-002

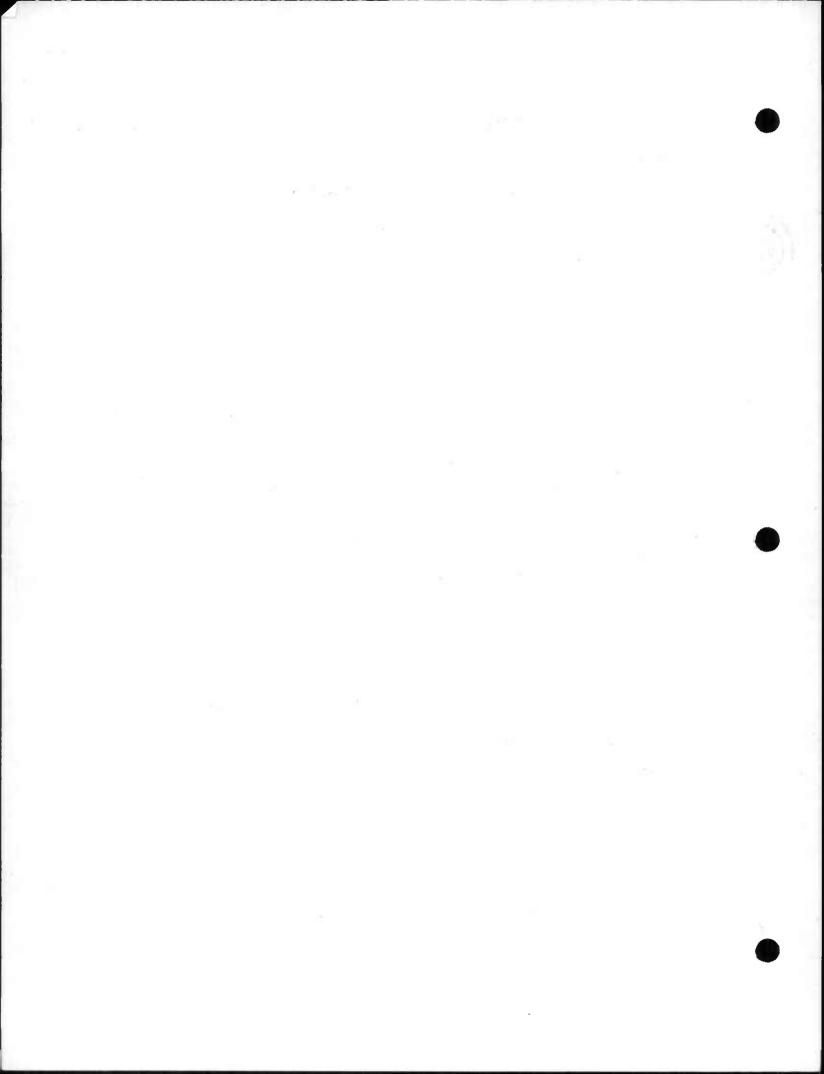
DIVISION OF VITAL RECORDS, P.O. BOX 68760

DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	CATE O	DEATH	RE	G. NO.					
	1. DECEDENT'S NAME (First, Middle, Last) JOSEPH E	SALYARDS				2. DATE OF DE MONTH FEBRUA	ARY 2,	1995	3. TIME OF DEA	тн Р м		
	4. SOCIAL SECURITY NUMBER			IF UNDER 1 YEAR		7. DATE OF BII (Month, Day,	RTH Year)	8. BIRTI	IPLACE (State or Form)	oreign		
	235 32 6264	1X M 2 □ F 68	3 YRS.			yser, W	7					
nr.	9a. FACTLITY NAME (If not institution, give s	Chicago Co.		96. CITY, TOWN OR LOCATION OF DEATH					9c. COUNTY OF DEATH			
DIRECTOR	SACRED HEART HO	SPITAL		CUMBERLAND ALLEGANY								
黑	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOC	ATION				10d. INSIDE CITY			
	Wv Miner	al	New	Creek					1 TES 2	NO		
FUNERAL	10e. STREET AND NUMBER	-		1	Of. ZIP CODE		10g. Cf	TIZEN OF	WHAT COUNTRY?			
	P.O. Box 96				26743			S.A.				
₽	11. MARITAL STATUS 1 Never Merried 2 Marriad	12. WAS DECEDENT EVER FORCES? 1 Y YES IF YES, GIVE WAR OR I	IN U.S. ARMED	It yes,	CENDENT OF HISPAI specify Cuben, Maxica	in, Puarto Rican,	ecify Yes or No-	14. RAC Blac	E — Americen Indi k, White, atc.	en,		
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR I	DATES	1 🗀 YI	S 2 XIO Specif	y:		Spec	www. White	<u> </u>		
	15. DECEDENT'S EDU		18e. DECEDENT'S U	SUAL OCCUPAT	TON	18b. KIND	OF BUSINESS/IN	IDUSTRY		-		
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of wo	ork done during r retired.)	nost of working					1		
필	12		Posta	1 Cler	k	Po	stal					
8	17. FATHER'S NAME (First, Middle, Last)	-	-		18. MOTHER'S NA	ME (First, Middle,	Maiden Sumame)					
B	Joseph M. Salyar	ds .			Eva Ch							
2	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural							
	Larry Salyards				t Drive P							
	20e. METHOD OF DISPOSITION 1 X Burlat 2 Cremation 3 Rem	ovat from State	b. PLACE AND DATE OF metery, crematory or oth OTOMAC MEM	er piace)	Varne of	DATE	20c. LOCATION -		own, State			
	4 Donation 5 Other (Specify)		otomac Mem		Sarden 2/		Keyser,					
!	1/2/20 /4X	///	0			Mar	kwood M					
-	OC PART I February	mue x	42		S. Minera							
	23. PART i. Enter the disease, or cehock, or heart failure.	List only one ceuse on	each line.	t enter the n	ode of dylng, euc	h es cardiac o	r respiratory a	rraet,	Approxim Interval B			
	ehock, or heert failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition) reaulting in death) Due to (or as a consequence): Sequentielly liet conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):											
	reaulting in death)	a. T KLYM D	M CONSECUTENCE OF	CY	n holi	5 m			1 h	Y		
_		5 m lo. 1.	S. C. and s.	0	ا ما ٧٠٠	ا ما ه	100	1.	w 20	1		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF)	9 ~	0110	C103	00	144	1 20	Lano.		
CA	cause. Enter UNDERLYING CAUSE (Disease or Injury	с										
E	thet initieted events resulting in deeth) LAST	DUE TO (OR AS	A CONSEQUENCE OF)									
Ä	resulting in destri) Exst	d							_			
7	PART II. Other significent condition	e contributing to death	but not resulting In	the underly	ng cause given in		WAS AN AUTOPSY	24b	. WERE AUTOPSY F			
EDICAL	PonaPlegi	9					PERFORMED?		AVAILABLE PRIOR COMPLETION OF			
MEC									OF DEATH?	NO		
	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	OF DEATH YES	□ NO I	UNCERTAIL	N D						
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPIJAL:	26. PLACE OF DEATH)							
XS.	1 TES 2 DAG	1 Dispetient 2 ER/Out		OTHER: Nursing Ho	me 5 🗆 Realdenca	8 Other (Spec	cify)					
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF tNJURY (Month, Day, Year)	28b. TIME INJU		IJURY AT	28d. DESCRIBE	HOW INJURY O	CCURED				
B	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO							
- 1	3 Suicida 8 Could not be 4 Homicide detarmined	28e. PLACE OF INJUR building, atc. (Spe	Y — At home, tarm, str cify)	sat, factory, off	lca	28t. LOCATION City or Town	(Street and Number n, State)	er or Rural i	Route Number,			
E						<u></u>						
COMPLETED	ann)	CIAN: To the best of my know								- 1		
8	2 MEDICAL EXAMINE	R: On the baels of axamination	on end/or investigation.	In my opinion,	death occured at the	tima, date and p	laca, and due to	the ceuse(s	i) end menner aa s	stated.		
BE	29b, SKONATURE AND TITLE OF CERTIFIER	· ~			29c. LICENSE NUI	MBER			(Month, Day, Year)			
2	30 NAME AND ADDRESS OF BEDOOD WILL	12).	PATAL STEPA		10125	33	PFI	EBRUA	WI 3	15-		
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DI		rint) 5 Se	fon D	v. e	umbe	rla	Con			
	FEB 0 6 199	32 REGISTERAR'S SIGN				-		Ma	1.2150	2		
- 11	1001	. /										



DIVISION OF VITAL RECORDS, P.O. BOX 68760,	BALTIMORE, MARYLAND 21215-0020
TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physicis	hours after death. Page 6 may be retained by the hospital or attending physici
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-t	ly filled in by the funeral director, page 5 should be detached for use as the burial-
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ation, or removal.
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	the medical examiner must be notified at once.

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											95	0	4819)
	FOR 1 - STATE REGISTRAR	STATE OF	MARYLAND /	DEPAF ERTIF	RTMENT	OF H	IEALTH AI DEATH	ND MI		YGIEN	E			
	1. OECEDENT'S NAME (First, Middle, Last)								2. DATE OF	DEATH			3. TIME OF DEAT	ГН
	Charles	L.	Schu	2					Jan.	29 29	199	YEAR	2:15	Р.м
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. las	,,	IF UNDER	DER 1 YEAR IF UNDER 24 HRS. B DAYS HOURS MIN.							PLACE (State or Fo	
	215-20-6382	1 M 2 F	68	YRS.	MONTHS	DAYS	HOURS	III	Feb.	3, 19	926			
_	9a. FACILITY NAME (If not institution, give s				9b. CITY,		OR LOCATION		гн		NTY OF D			
0	1 Jenkins Street	t		Frostburg							Alleg	any		
EC.	10e. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN O	R LOCAT	TION					10d. INSIDE CITY	,	
FUNERAL DIRECTOR	Maryland	7			1	Frostb	urg					LIMITS?	NO	
AL.	10e. STREET AND NUMBER				101	. ZIP CODE	4.0			10g. CIT	ZEN OF W	HAT COUNTRY?		
ÉFI	1 Jenkins Stree					215	32		_		U.S.	A.		
5	11. MARITAL STATUS 1 Never Married 2 Merried	T EVER IN U.S. AR	MED 10	13. W	AS DEC	ENDENT OF H	HSPANIC fexican.	ORIGIN? (S	pecify Yea	or No-	14. RACE Black	- American India White, atc.	an,	
BY	3 Wildowed 4 Divorced	MAR OR DATES		1	_ YES	2 💹 NO	Specify:		.,,		Specif	y:		
ED	15. DECEDENT'S EDU	CATION	16a. DE	CEDENT'S	USUAL OC	CUPATIO	ON		16b, KIN	D OF BUS	INESS/IND		hite	
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	(Gi	Do NOT us	work done di se retired.)	uring mo	st of working					,,,,,,,		
COMPLETED	12	0	(Owner	· & O	pera	ater			Ret	ail	Jewe	lry	
잉	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER			e, Maiden :				In .
B	John	Irvin		chutz			-	lvia					tson	
7	19a. INFORMANT'S NAME (Type/Print) Wilma Schutz 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1 Jenkins Street Frostburg, Maryland 21532													
	20e. METHOD OF DISPOSITION 1													
	21. SIGNATURE OF FUNERAL SERVICE UCENSEE 22. NAME AND ADDRESS OF FACILITY Durst Funeral F													
	57 Frost Avenue Frostburg, Md. 2153													
	23. PARD. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line.											Approximation interval Be		
	IMMEDIATE CAUSE (Final disease or condition										Onset and	Death		
	resulting in death)	a. Hyrxrtensive cardiovascular heart disease										y:	rs	
TIFICATION	Sequentially list conditions,	DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
AT	if any, lasding to immediata cause. Enter UNDERLYING				,								İ	
E	CAUSE (Disease or Injury that initiated events	DUE TO	(OR AS A CONSEC	UENCE O	F):								+	
<u> </u>	resulting in dasth) LAST	d												
ပျ	PART II. Other significant condition	na contributing to	death but not ra	asulting i	n the und	larivino	cause alva	n In Pa	rt 24a	. WAS AN	MITTOREY	245	WERE AUTOPSY FII	NDINGO
S	Colitis			accounting .	in the one	arrynns	cause giva	III III FA		PERFORI		240.	AMILABLE PRIOR COMPLETION OF C	TO
	002202								- 10	YES 2	No.		OF DEATH?	
≥	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DEA	TH YE	SIN	o k	UNCER	TAIN		,			1 YES 2 N	10
NA I	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			-	H (Check or		OTTELK	IZILY						
SIC	1 YES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER:		5 Reelde	ence 6	Other (Sp.	ecify)				
BY PHYSICIAN: MEDICAL	27 MANNER OF DEATH 1 Natural 5 Pending	26a. DATE OF (Month, D		28b. TIM INJ	E OF 2	26c. INJU WOI	UPY AT	20	6d. DEŞCRIE		JURY OCC	CURED		
8	2 Accident 3 Sulcide 4 Homicide 6 Could not be determined	26e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 26l. LOCATION (Street and Number or Rural Route Number of Building, etc. (Specify)									oute Number,			
۳	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner se stated.													
COMPLET	one) 2 MEDICAL EXAMINE	H: On the beals of a											and manner as st	lated.
BE (290. SIGNATURE AND TITLE OF CERTIFIES		-		-		29c. LICENSE	E NUMBE	R		29d. DATI	E SIGNED	(Month, Day, Year)	prob

ID LORACCO DSE CONT	RIBUTE TO CAUSE OF DEATH Y	ES NO X	UNCERTAIN
AS CASE REFERRED TO MEDICAL		ATH (Check only one)	
YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA	OTHER: 4 Nursing Home	5 Residence 6

9

D09157

Dpty Med Ex 10. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Snow,

124

W. 3rd Street

Cumberland, Maryland 21502

31. DATE FILED (Morith, Day, Year)
FEB 0 6 1995 32 REGISTRAR'S SIGNATURE

M.D.

Feb 6, 1995

..... 88. (a)

	1 - STATE REGISTRAR	STATE OF MAR				HEALTH AND	MENTAL	HYGIENI	E			
	DECEDENT'S NAME (First, Middle, Last, Mary Earlene Sm					 -	2. DATE MONTH 02	OF DEATH		YEAR S	3. TIME OF DEATH 6:01 P. M	
	4. SOCIAL SECURITY NUMBER 218-38-2499	1 🗌 M 2 😾 F	NGE (In yrs. last t		UNDER 1 YEAR NTHS DAYS		(Month	OF BIRTH , Day, Year) /10/41		Country)	LACE (State or Foreign	
5	9a. FACILITY NAME (If not institution, give Sacred Heart Ho			96	96. CITY, TOWN OR LOCATION OF DEATH Cumberland, Maryland Alle						egany	
DIRECTOR	10e. STATE 10b. COUN	тү	Т	10c. CITY, TO	OWN OR LOC	ATION					IOd, INSIDE CITY	
	Maryland Al	legany		Cur	nber1a	ınd				1	LIMITS?	
EHAL	13530 POPPY ST	REET S.W.				21502				S.A.	IAT COUNTRY?	
BY FUNER	11. MARITAL STATUS 1 Never Married 2 A Married 3 Widowed 4 Divorced	ER IN U.S. ARMI VES 2 NO OR DATES	ED	If yes,	ECENDENT OF HISPA specify Cuban, Maxics ES 2 1 NO Specif	an, Puarto F		or No	Black,	- American Indian, White, etc. WHITE		
WEELED.	15. DECEDENT'S ED (Specify only highest grac Elementary/Secondary (0-12)	UCATION te completed) College (1-4 or 5+)	(Give	kind of work to NOT use re	tired.)	TION THOSE Of WORKING		TEAC		ISTRY		
BE COMPL	17. FATHER'S NAME (First, Middle, Lest) HAROLD H. MILLE	R				18. MOTHER'S NA MARY						
2	190. INFORMANT'S NAME (Type/Print) ARTHUR C. SMITH					TREET S.V					AND 21502	
	20e. METHOD OF DISPOSITION 1∑⊉urial 2 ☐ Cremation 3 ☐ Raid 4 ☐ Donation 5 ☐ Other (Specify)	movel from State	206 PLACEAN FROSTBU			Name of L PARK F	EB 7		ROSTE			
	21. SIGNATURE OF FUNERAL SERVICE	We with	>			AND ADDRESS OF FA				MAR	ON AND	
	IMMEDIATE CAUSE (Final disease or condition) (Managed and 7 / 7)											
RIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST											
AL CE	PART II. Other aignificant condition	ons contributing to dear	he underlyi	nderlying cause given in Part I. 24a. WAS					VERE AUTOPSY FINDINGS WAILABLE PRIOR TO			
MEDIC							_	1 TYES 2	Хио	0	COMPLETION OF CAUSE OF DEATH?	
SICIAN	DID TOBACCO USE CON' 25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CAUSE					N 🗆					
2	EXAMINER?	HOSPITAL:		1 100	THER:		10.0	La Francis				
i l	27. MANNER OF DEATH Natural 5 Pending	28a. DATE OF INJU (Month, Day, Ye	IRY	26b. TIME OF	28c. H	NJURY AT VORK? YES 2 NO		CRIBE HOW IN	IJURY OCCL	PRED		
	Natural 5 Pending						28f. LOCA	ATION (Street all or Town, State)	nd Number o	r Rural Roo	ute Number,	
MITLE		SICIAN: To the beat of my k									and manner as stated.	
3	29b. SIGNATURE AND TITLE OF CERTIFIE					29c. LICENSE NUI					Vonth, Day, Year)	
	Jan	V				D212			1 5	1	150	
	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF	DEATH (ITEM :	27) (Type, Prin	nt)					, ,		
	DR JESUS TAN F 31. DATE FILED (Month, Day, Year)	ROSTBURG PL 32. REGISTRAR'S S	AZA FI	ROSTBI	JRG MA	ARYLAND	2153	2				
	FFB 0 6 1995	Jahr Davide	ex-proved	1							DHMH-16 Rev 1/89	

BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physics	rilled in by the funeral director, page 5 should be detached for use as the burlait	tion, or removal.	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physical	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnet.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BE

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH JOHN WILLIAM SPRIGGS FEBRUARY 1995 AM 12:16 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 6. BIRTHPLACE (State or Foreign 1 X M 2 - F 214-07-6622 27. Apr 9a. FACILITY NAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MEDICAL DIRECTOR MEMORIAL HOSPITAL & CENTER CUMBERLAND ALLEGANY 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Allegany Cumberland YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE tog. CITIZEN OF WHAT COUNTRY? 13310 Uhl Highway SE USA 21502 t2. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO If yes, specify Cuben, Maxican, Puerto Rican, atc.) 1 Never Merried 2 Merried 1 TES 2 NO Specify: BY 3 ₩ Widowed 4 Divorced white ETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Retired 12 Textile 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ BE Ruth C. (Karns) Thomas H. Spriggs notified 19a, INFORMANT'S NAME (Type/Print 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 John T Spriggs Cumberland, MD 21502 þe 20a METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata DATE must Burial 2 Cremation 3 Removal from State Donation 5 - Other (Specify) 02/04 Memorial Cemetery Cumberland, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland MD 21502

Iter the mode of dying, such as cardiec or respiratory arrest, medicai 23. PART V Enter the diseases, or complications that of shock, or heart failure. List only one cause Approximate on each line. IMMEDIATE CAUSE (Final Onset and Death the disease or condition_ resulting in death) event, traumatic CERTIFICATION Sequentially list conditions, NSEQUENCE OF if any, leading to immediate cause. Enter UNDERLYING **CAUSE** (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceues given in Part I. 24s. WAS AN AUTOP MEDICAL TIVES PERFORMED? AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 YES 2 NO 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES D NO 🗌 PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL:
1 Unpetient 2 - ER/Outpetient 3 - DOA 1 YES 20 NO OTHER: 0 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. t Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, term, street, fectory, office building, etc. (Specify) 3 Sulcide 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 28 4 Homicide item 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(a) and menner ea stated. MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the ceuse(a) end manner as stated.

29c. LICENSE NUMBER

D16041

MEMORIAL HOSPITAL MEDICAL BLDG., CUMBERLAND, MD SP REGISTRAR'S SIGNATION

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

TERRY WILLIAMS M.D.

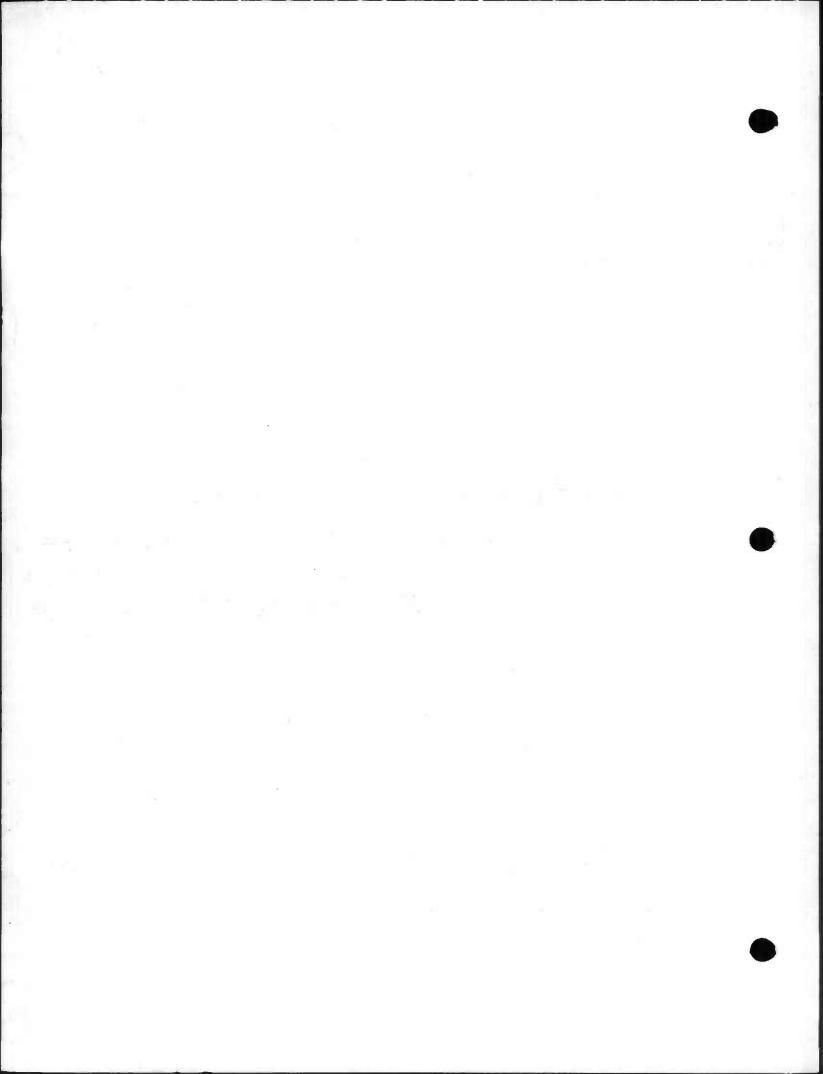
EEB 0 3 1995

31. DATE FILED (Month, Day, Year)

29d. DATE SIGNED (Month, Day, Year)

2-45

21502

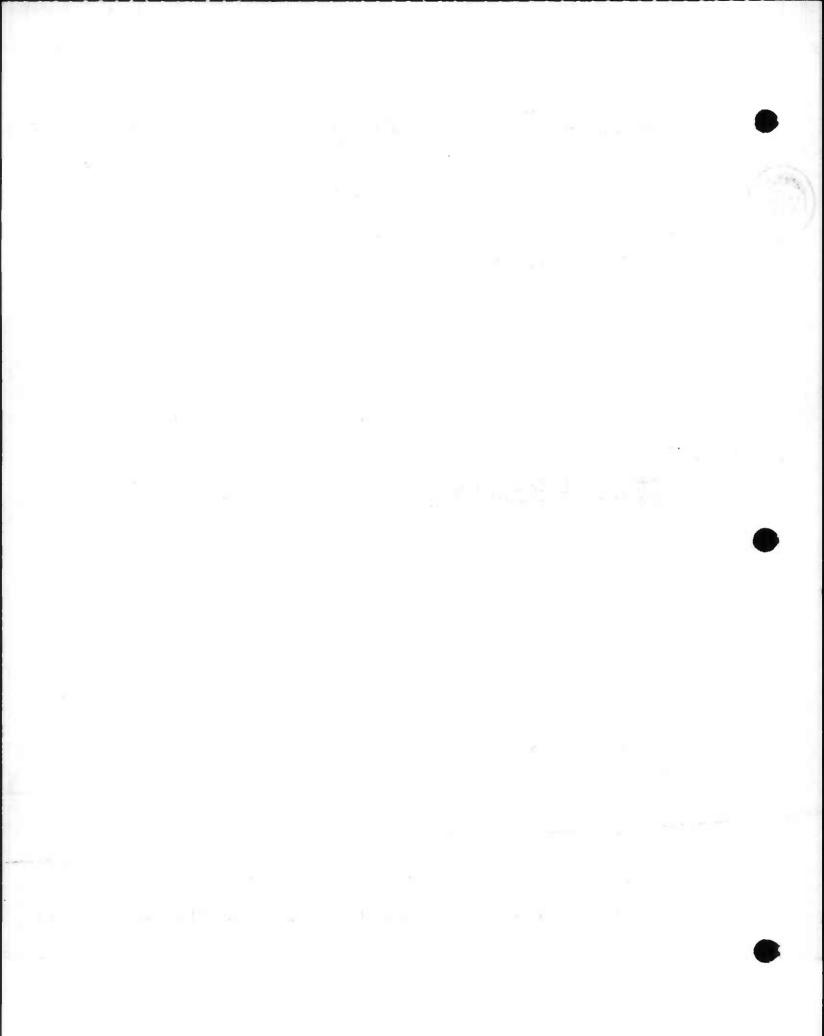


1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGISTHAH			ICATE O		REG. NO	•				
	1. DECEDENT'S NAME (First, Middle, Last) FLOSSIE K. 2			NLEY			YEAR 95 (AE OF DEATH			
	4. SOCIAL SECURITY NUMBER 5. SE	Y A ACE	In yrs. last birthday)	IF UNDER 1-MA	1 1 1 1 1 1 1 1 1 1 1 1 1 1			0	2		
	111000000000000000000000000000000000000	M 2/3/F 9(MONTHS DAY	The second second	7. DATE OF BIFTTH (Month, Day, Year) May-30-1	904	Country)	State or Foreign		
	9e. FACILITY NAME (If not institution, give street and	d number)		9b. CITY, TOW	N OR LOCATION OF D	EATH		NTY OF DEATH	2110		
Œ	Dorchester Gener		+-1								
2	RESIDENCE OF DECEDENT	ar nosp.	Ltal	Camb.	ridge		porc	cheste	r		
	10a. STATE 10b. COUNTY		10c CIT	Y, TOWN OR LO	CATION			1 404 1	NOIDE OFFI		
<u>E</u>								10d. 1	NSIDE CITY		
۹.	Maryland Dorches	ter	<u>Ca</u>	mbrid	ge			1 💢	YES 2 NO		
₹	10e. STREET AND NUMBER				10g. CITIZEN		ZEN OF WHAT C	OUNTRY?			
6	406 Pine Street				USA						
FUNERAL DIRECTOR	11. MARITAL STATUS 12. W	AS DECEDENT EVER IN	U.S. ARMED	13. WAS E	NIC ORIGIN? (Specify Yes	or No-	14 PACE _ Am	sericen Indian			
	1 Never Married 2 Married	ORCES? 1 YES	2 NO	If yes,	in, Puerto Rican, atc.)			. RACE — American Indian, Black, White, atc.			
B	3 X Widowed 4 Divorced	TES, GIVE WAR OR DA	NES	1 1 1	ES 2 NO Specif	y:		Specify: B.	lack		
0	15. DECEDENT'S EDUCATION		16a. DECEDENT'S	Hellar occurs	71011						
Ë l	(Specify only highest grade complete		(Give kind of w	vork done during se retired.)	most of working	16b. KIND OF BU	SINESS/INC	DUSTRY			
ا ت		ge (1-4 or 5+)				Univ	C++	ling			
₹	0-12		Beaut	<u>ıcıan</u>		naii	SUY	ring			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden	Sumame)				
BE	Charles Ke	ene			Liza	Camper					
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	at and Number or Rural	Route Number, City or Tow	n, State, Zic	Code)			
임	Agnes Wilson					ington, D					
	20a METHOD OF DISPOSITION	200	PLACE AND DATE O								
	XX Buriel 2 Cremetion 3 Removal Iro	om State cem	etery, crametory or of	her place)				Cify or Town, Sta			
	4 Donation 5 Other (Specify)	[Wa	augh UM			2-8 Cam	bric	ige MD	21013		
- 1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	1.1		22. NAME	AND ADDRESS OF FA	L.H. B	oard	llov F	/H		
- 1	Jan H Ba	77	112	010	TT1-1						
\dashv	22 BADY I Seter the disease of a set in	wiene		012	нирраго	St. Cqa	mprı	lage, M.			
	23. PART I. Enter the diseases, or complice shock, or heart fallure. List on	nly one cause on e	i the death. Do n ech line.	ot enter the i	noda of dying, suc	h aa cardiac or reap	ratory an		Approximete Interval Batween		
	IMMEDIATE CAUSE (Final) Onset and							Onset and Death			
	resulting in death) a. Kenal Failure Renal Failure 36 h							36 ha			
			CONSEQUENCE OF						00 111		
z	-	Sensi	< Se	psis					3 Days		
의	Sequentially llat conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):							5 - 29 5			
⋝∥	cause. Enter UNDERLYING							-	1		
\sim \parallel	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):										
HIE!	that initiated events resulting in death) LAST	DUE TO (OR AS A		d							
CERTIFI		DUE TO (OR AS A									
L CERTIFICATION	resulting in death) LAST		ut not resulting i	n the underly	ing cause given in	Part I. 24s. WAS AN	AUTOPSY	24b. WERE	AUTOPSY FINDINGS		
			ut not resulting i	n the underly	ing cause given in	PERFOR	MED?	AVAILA	AUTOPSY FINDINGS BLE PRIOR TO		
	resulting in death) LAST		ut not resulting i	n the underly	ing cause given in		MED?	AVAILA	BLE PRIOR TO LETION OF CAUSE		
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EDICAL	resulting in death) LAST	ributing to deeth b				PERFOR	MED?	AWAILA COMPI OF DE	ABLE PRIOR TO LETION OF CAUSE ATH?		
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BE COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other algnificant conditions contributed by the second s	TE TO CAUSE O PITAL: npetient 2 ER/Outp 18e. DATE OF INJURY (Month, Day, Year) 18e. PLACE OF INJURY building, stc. (Special to the best of my known the basis of exemination to the exemination to the e	F DEATH YE 28. PLACE OF DEAT atlant 3 DOA 28b. TIME [IN.J! At home, term, s edge, death occurre a end/or investigation ATH (ITEM 27) (Type,	S NO M (Check only or OTHER: A Nursing H E OF URY M 1 1 dreet, lactory, of d at the time, d n, in my opinion Print)	UNCERTAIN Dome 5 Residence NJURY AT WORK? YES 2 NO Notice The and place, and due It death occurred at the	8 Other (Specify) 26d. DESCRIBE HOW I 281. LOCATION (Street City or Town, State) to the cause(a) and maintime, data and place, and MBER	NJURY Octand Number	CURED CURED Tor Rural Route No. Ted. The cause(a) and marks are cause(b) and marks are cause(c).	IBLE PRIOR TO LETION OF CAUSE ATH? VES 2 1 NO Imber,		



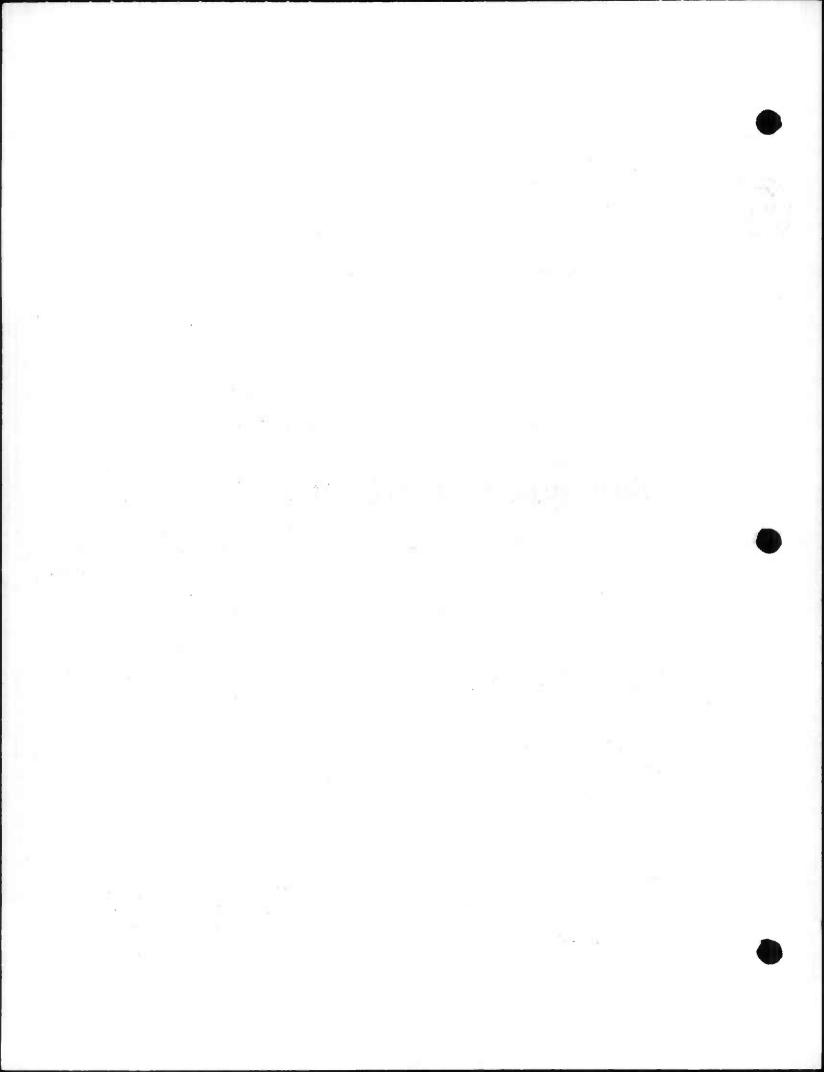


. BOX 68760 BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	her traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certif	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.										
1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH		3. TIME OF DEATH		
WILLIAM SMITH						JANUARY 3		YEAR		
4. SOCIAL SECURITY NUMBER 5	. SEX 8. AGE	(in yrs. lest birthday)	IF UNDER 1 Y		7	7. DATE OF BIRTH		B. BIRTHPLACE (State or Foreign		
21/1 10 1/06	M 2 D F	YRS.	MONTHS	HOURS	MIN.	(Month, Day, Year) 08/08/19	20	Maryland		
Sa. FACILITY NAME (If not institution, give stree				OWN OR LOCATI	ON OF DE		9c. COUNT	TY OF DEATH		
NORTH ARUNDEL HOS	SPITAL ASSO	CIATION	GLEN	BURNIE			AAC	0		
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		40- 0174								
	-b +	10e. CITY,	TOWN OR					10d. INSIDE CITY LIMITS?		
Maryland Dor	chester		Win	gate				1 TYES 2 NO		
	_1	7 7 7		101. ZIP COD	_	e	10g. CITIZE	EN OF WHAT COUNTRY?		
2152 Wingate Bi			1		2167			U.S.A.		
1 Never Married 2 Married	FORCES? 1 YES	2 NO	It y	es, specify Cubs	ın, Maxica	HC ORIGIN? (Specify Yea n, Puerto Rican, etc.)	or No — 1	14. RACE — American Indian, Black, White, etc.		
3 Wildowed 4 Divorced	World War on t		1 [YES 2 X NO	Specify	<i>r:</i>		White		
15. DECEDENT'S EDUCAT	ION	18a. DECEDENT'S L	JSUAL OCCI	JPATION		16b. KIND OF BUS	INESS/INDU			
(Specify only highest grade cor Elementary/Secondary (0-12)	npleted) College (1-4 or 5+)	(Give kind of we	ork done duri	ng most of working	ng	125211177455555				
, , , , , ,	2	Parts	Dist	ributo	or	Dis	tribu	ution		
17. FATHER'S NAME (First, Middle, Last)				18. MOTI	HER'S NA	ME (First, Middle, Maiden :	Sumame)			
illiam Godfred S	mith				Ber	tha Amel:	ia Ko	neh l		
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (S	treet and Number		Route Number, City or Town				
Melanie S. Tavl	or					rth, Gle		21001		
20e, METHOD OF DISPOSITION 1 N Burial 2 □ Cremation 3 □ Remove		PLACE AND DATE OF			110			ity or Town, State		
4 Donation 6 Other (Specify)	from State	Dery, cre-Velever eth	rans	Cem E	E.S.	2-3		ock, MD.		
21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE /		22. NA	ME AND ADDRES	SS OF FA	CILITY				
- Talley Fore	n- Bro	nucl	30	8 Hiah	ı St	., Cambr:	idae,	Home, P.A., MD. 21613		
23. PART I. Enter the distance or con	plication(a thet ceuse	d the death. Do no	ot enter th	mode of dy	ing, suci	h aa cardlec or reapir	atory arres	st, Approximeta		
ahock, or heart effure. List only one ceuse on each line. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) e. ACUTO Left Homes And Death 2 Day,										
o	DUE TO (OR AS	CONSEQUENCE OF	F		, 3.	7116		MA DEMAS		
Constalle lie and distance of b.	Alma	F	1 4-	- 110	10			11/94		
Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	CONSEQUENCE OF)	:			,				
CAUSE (Disease or injury										
that initieted eventa reaulting in deeth) LAST	DUE TO (OR AS	CONSEQUENCE OF)	:							
d										
PART II. Other aignificant conditions of	ontributing to death b	out ngt resulting in	the unde	rlying cause o	lven in	Part I. 24s, WAS AN	WTOPSY	24b. WERE AUTOPSY FINDINGS		
Mys cars	9 Ja		(no	1		PERFORI		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
me to make is	MILLAN	CW	010	1.0	/	1 YES 2	ANO	OF DEATH?		
DID TOBACCO USE CONTRIB	LITE TO CAUSE O	E DEATH VE			EDTAIN	9-4		1 YES 2 NO		
25. WAS CASE REFERRED TO MEDICAL	OTE TO CAUSE C	26. PLACE OF DEATH			ERTAIN	N LEFT				
	OSPITAL:		OTHER:							
27. MANNER OF DEATH	26a. DATE OF INJURY	28b. TIME	-	c. INJURY AT	sidence	6 Other (Specify) 28d. DESCRIBE HOW IN	Him Acar			
1 Natural 5 Pending	(Month, Day, Year)	INJU	RY	WORK?	٦ ٧٥	200. DESCRIBE HOW IN	JUNY OCCU	HED		
2 Accident Investigation	26s. PLACE OF INJURY	- At home form et		YES 2] NO	201 2017 21 (2)				
3 Suicide 6 Could not be determined	building, etc. (Spe	cify)	reet, factory,	OINCE	i	28f. LOCATION (Street as City or Town, State)	nd Number or	Rural Route Number,		
29e. CERTIFIER				-						
229. CERTIFFUNG PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and piece, and due to the cause(a) and menner as stated. (Check only one) 2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(a) and manner as stated.										
	In the basis of examinatio									
29b. SMINATURE AND TITLE OF CERTIFIER	on the basis of examination			29c. LICE	NSE NUM	IBER I	29d, DATE 5	SIGNED (Month, Day Year)		
	The basis of examination			29c. LICE	NSE NUM	BER U U	29d. DATE 5	SIGNED (Morith, Day, Year)		
29b. SHANATURE AND TITLE OF CERTIFIER	Dun	ATH (ITEM 27) (Type. F	Print)	29c. LICE	3/2	IBER 44	29d. DATE S	SIGNED (Month, Day, Year)		
	OMPLETED CAUSE OF DE	INGTON AV		123	3/2	44	> /	-31-95		



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE Q5 FOR STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH TIME OF DEATH 1925 Robert Henry Shenton 995 Ian 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Dey, Year)
Oct 3,1900 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MONTHS DAYS 213-20-2896 HOURS 1XXM 2 - F Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Dorchester General Hospital Cambridge Dorchester RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Dorchester Tavlors Island 1 TYES XX NO FUNERAL 10e. STREET AND NUMBER 10t, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4208 Robinson Neck Road 21669 US 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Mexican, Puarto Rican, etc.)
1 ☐ YES ※ NO Specify: 14. RACE — American Indian, Black, Whita, alc. FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married Specify: White BY 3 Widowed 4 Divorced COMPLETED 15. OECEDENT'S EOUCATION 18a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondery (0-12) College (1-4 or 5+) Store Keeper/Waterman 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Moses Shenton 듇 Jennie Foxwell BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary Virginia Wheeler 402 Robinson Avenue Cambridge, Maryland 21613 pe 20a, METHOD OF DISPOSITION

| New York | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State must Dorchester Memorial Park 2/2 4 Donellon 5 Donellon Other (Specify) Cambridge, Maryland the medical examiner 21 SIGNATURE OF MINERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust Street Cambridge, Maryland 21613 23. PART / Entar the diseases, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or heart failure. List only one cause on each line interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition resulting in death) .Cerebrovascular Accident event, 24 hs TO (OR AS A CONSEQUENCE OF): askinger traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury or other TO (OR AS A CONSEQUENCE OF): that initiated evants resulting in death) LAST PART ii. Other algolificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any 1 TES 2 HO Shows 1 TES 2 HO **PHYSICIAN**: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) certificate to the State of the State of the State of the State of the state of the HOSPITAL: OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) 1 YES 2 NO etlant 2 ER/Outpetlent 3 DOA 27. MANNER OF OEATH 28b. TIME OF 28e. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO В Investigation 2 Accident 28e. PLACE OF INJURY — Al home, term, street, factory, office building, alc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) S COMPLETED 6 Could not be DIRECTOR: / 4 Homicide 28 datarmined TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT DE filed within 72 hours at IMPORTANT: If Item 2 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. S/GNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE 1114 30/9 phy gu assende 2 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 400 Aurora Street Vinodrai Mehta, M.D. Cambridge, MD 21613 31. OATE FILED (Month, Day, Year) 32, REGISTRAR'S, SIGNATURE

Talia attivales Rardall

BALTIMORE, MARYLAND 21215-0020

after death. Page 6 may be retained by the hospital or attending physic

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funeral director, page 5 should be detached

the attending physician and completely filled in by the I Mental Hygiene prior to bunal, cremation, or removal.

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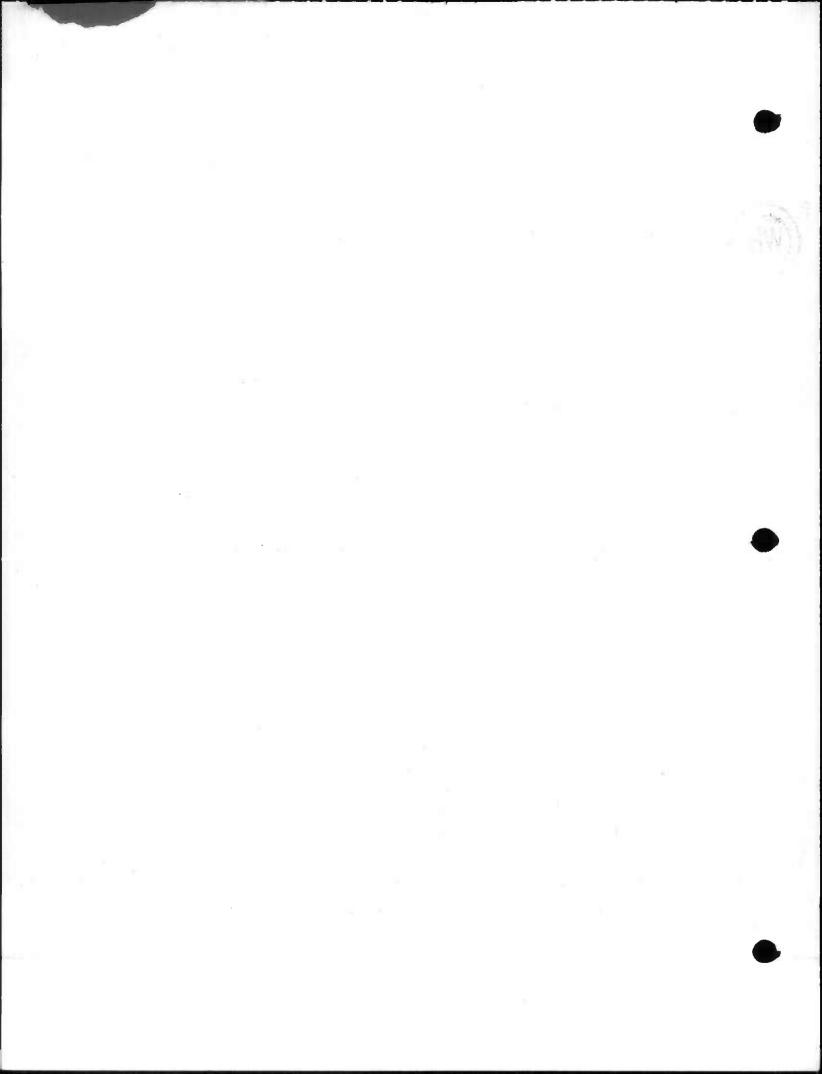
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OR ATTENDING PHYSICIAN:

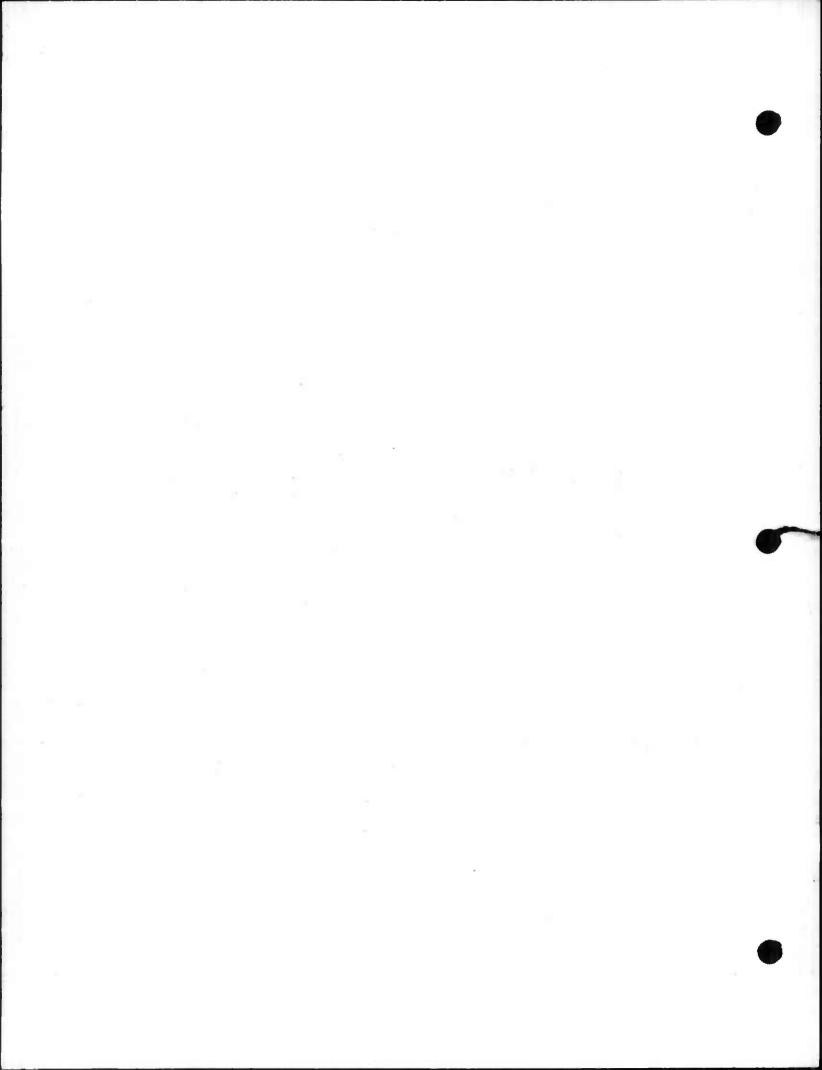
DIVISION OF VITAL RECORDS, P.O. BOX 68760,



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BALTIMORE, MARYLAND 21215-0020	4 hours after death. Page 6 may be retained by the hospital or attending physician.	filled in by the funeral director, page 5 should be detached for use as the burial-transit per	in, or removal.	e medical examiner must be notified at once,
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It lem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	Amended 7 FOR 1 - STATE PRECIETEDAD	#-1 1/2	6/95	- 1	DRT	0	12	ta	9!	5 0	4825		
_	REGISTRAR	STATE OF MARYL	AND / DEP CERT	ARTMEN IFICATI	T OF HEALT E OF DE	H AND I		REG. VNO.	E	d	7		
	1. DECEDENT'S NAME (First, Middle, Lest) Wanet ANETA M	SWIHART					JANU		4, 199	YEAR 3.	TIME OF DEATH 11:57pm		
	4. SOCIAL SECURITY NUMBER 317-16-7802	5. SEX 6. AGE	(In yrs. last birthdi 71 YRS	MONTHS	DAYS HOURS	DER 24 HRS.	7. DATE O (Month, OCt.	F BIRTH Day, Year) 27, 1	923	8. BIRTNPLA Country) India	CE (State or Foreign		
DIRECTOR	9a. FACILITY NAME (If not institution, give JOHNS HOPKINS		CITY E	Balti	more	9c. COUN	TY OF DEATH	4					
	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT	Y	10c.		OR LOCATION					100	I. INSIDE CITY		
	Maryland Montg	omery	0	lney							LIMITS? YES 2 NO		
FUNERAL	3321 Tidewater Co	urt			101. ZIP CC	832				ted S			
J.	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER I FORCES? 1 YES		13.	WAS DECENDENT	OF HISPAN	NIC ORIGIN?	(Specify Yes			American Indian		
B	3 Widowed 4 L Divorced	IF YES, GIVE WAR OR D			1 - YES 2 X N	O Specify	у:	, etc.,		Canall.	White		
TED													
COMPLETED	12	College (1-4 or 5 +)		ıs Exa			I	nsura	nce C	Compan	у		
	17. FATHER'S NAME (First, Middle, Last) Haskell Hudson						ME (First, Min		Surname)				
10 BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAIL	ING ADDRES	\$ (Street and Number				n, State, Zip	Code)			
-	Joseph W. Swihart					ane,					and 20906		
	20a. METHOD OF DISPOSITION 1 ☑ Burisi 2 ☐ Cremalion 3 ☐ Ramovel from State 4 ☐ Donalion 5 ☐ Other (Specify) ☐ Date 20b. PLACE AND DATE OF DISPOSITION (Name of cemelety, cremalory or other place). Nor Deck Memorial Park 1/28 Olney, Maryland												
	22. NAME AND ADDRESS OF FACILITY Hines—Rinaldi Funer 11800 New Hampshire Avenue Silver Spring, Maryland 20904												
	23. PART I. Enter the diseases, or shock, or heart failure.	complications that cause List only one cause on e	d the dasth. D	o not entar	the mode of o	lying, suci	h ss cardle	c or respi	ratory srre		Approximate interval Between		
	iMMEDIATE CAUSE (Finsi disease or condition	Palumo	a che	Du e co							Onset and Death		
	resulting in dasth)	DUE TO (OR AS	11 4		N COLLEC						1 WEEK		
NO.	Sequentially list conditions, if any, isading to immediate	DUE TO (OR AS A	tailure CONSEQUENCE								1 week		
RTIFICATION	cause, Enter UNDERLYING CAUSE (Disease or injury	C. SEPSI	CONSEGNENCE	. 00							1 week		
ERI	that initiated events resulting in death) LAST		's DI								3 months		
O	PART II. Other significant condition	is contributing to death b	out not resulting	ng in the ur	nderlying cause	given in	Part i. 2	4a, WAS AN			RE AUTOPSY FINDINGS		
MEDICAL						_	_ [PERFOR	. 1	CON	ILABLE PRIOR TO MPLETION OF CAUSE DEATH?		
M	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	OF DEATH	YES 🗇 I	NO 🗹 UN	CERTAIN	<u>и</u> П			1 [YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF D		only one)	CERTAI							
HYS	1 YES 2 NO 27. MANNER OF DEATH	1 Supportion 2 ER/Outp		4 □ Nun	sing Home 5 28c. INJURY AT	Residence		Specify)	JURY OCC	URED			
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		INJURY M	WORK?	□ NO							
B	3 Suicide 8 Could not be 4 Homicide detarmined	28s. PLACE OF INJURY building, stc. (Spec	— At home, larr	m, street, fact	lory, office		281. LOCAT City or	ION (Street a Town, State)	nd Number o	or Rural Route	Number,		
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYS 2 MEDICAL EXAMINE	ICIAN: To the best of my know ER: On the besis of examination	ledge, death occ n and/or investig	urred at the t	ime, date end place	ce, and dua	to the cause time, data as	e(s) and man	ner es atate d due to the	d. cause(s) and	manner as stated.		
TO BE		IDENT M	Th	~	29c. Li	CENSE NUM	ABER		29d. DATE	SIGNED (Mod	ith, Day, Year)		
	30. NAME AND ADDRESS OF PERSON WAS MICHAEL (ELKER)	TOTALS HOPKINS			O N. WOL	FE S	T,	BALTIN	IONE	MO.	21205		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE POLICE					-					

DHMH-16 Ray 1/89



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Signed Health a

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TO THE HOSPITAL OF THE FUNERAL D Be filed within 72 ho

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OF VITAL RECORDS, P.O. BOX 88/80	MIVELETAM: The law requires that the death certificate he executed within
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Amended #18 #22 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH Feb. 2, 1995 Frank Joseph Stupcenski A SOCIAL SECURITY NUMBER 5 SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year)
July 14, DAYS HOURS 045-01-3972 1 🕅 M 2 🗌 F 1911 Connecticut 83 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN DIRECTOR 19114 N. Frederick Rd. Gaithersburg RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION Connecticut Hartford Canton 10e. STREET AND NUMBER 10f. ZIP CODE 06019 18 Lovely Street 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-PRCES? 1 YES 2
YES, GIVE WAR OR DATES If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: FORCES? 2 X NO 1 Never Married 2 Married BY COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+) 8 Machinist Collins Company 18. MOTHER'S NAME (First, Middle, Maiden Surname) Blinzeneiwic 17. FATHER'S NAME (First, Middle, Last) Marion Stupcenski Frances Blinzeneiewicz 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15613 Haddonfield Way, Darnestown, MD 20878 Mrs. Irene Lavorini 20a. METHOD OF DISPOSITION
1 A Burlel 2 Cremation 3 Removal from State
4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name 20c. LOCATION — City or Town, State OATE Mary s Cemetery 2/6 Avon, Connecticut 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Fome Home 10 E. Deer Park Dr., Gaithersburg, 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final cerebivos arlar disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING **CAUSE** (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL 10 1 | YES 2 10 110

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

MD 20877

Onset and Death

3 weeks

Approximata Interval Between

95 04826

3. TIME OF DEATH

10d, INSIDE CITY 1 X YES 2 | NO

14, RACE — American Indian, Black, White, etc.

White

B. BIRTNPLACE (State or Foreign

5:30 a. M

gomery

9c. COUNTY OF DEATH

Montgomery

10g. CITIZEN OF WHAT COUNTRY?

United States

1 YES 2 NO

25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 Inputient 2 ER/Outpetient 3 DOA ing Home 5 - Residence 8. Other (Specify) 6 roup 27. MANNER OF DEATH 28a, DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED 1 Natural 2 Accident 5 Pending Investigation м 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 4 Homicide

29a. CERTIFIER (Check only one)

1 CERTIFYING PNYSICIAN: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29c. LICENSE NUMBER

D19294

SIGNATURE AND TITL	LE OF CERTIFIER	releur	D	i	
JOHN	OF PERSON WHO	COMPLETED CAUSE	OF OEATH	(ITEM 27) (Type,	

AVE 911 RUSTELL

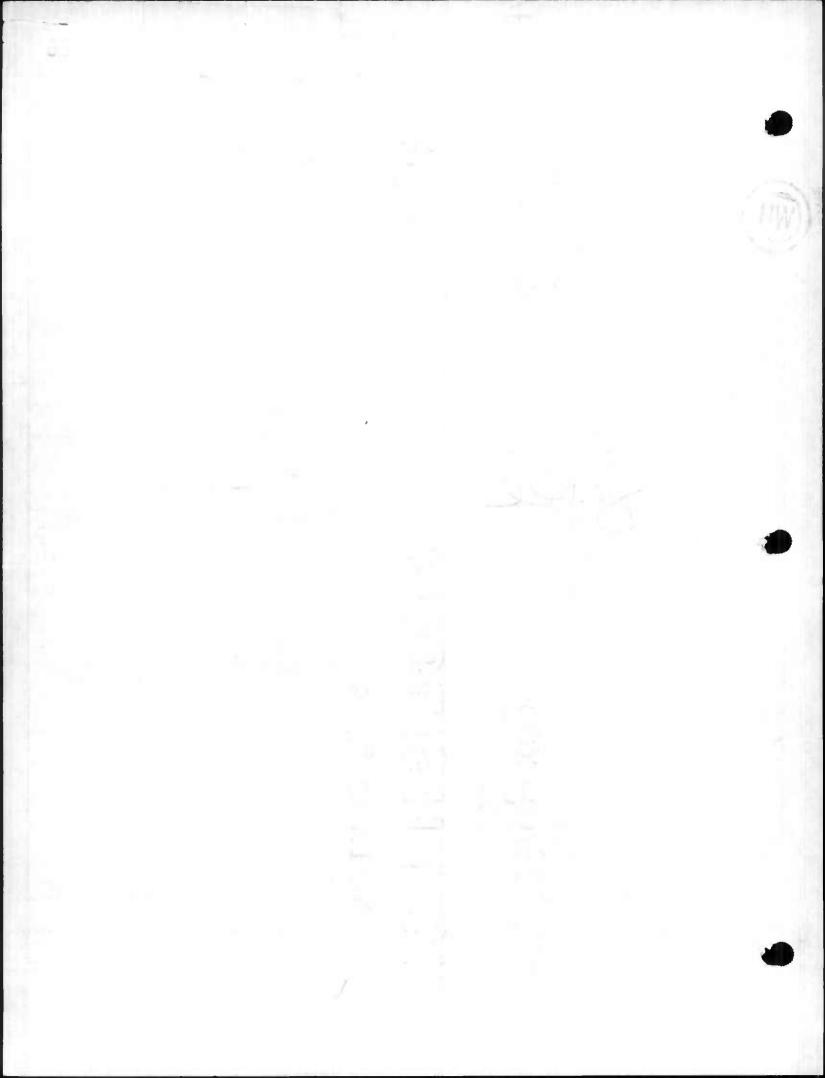
GAITHERS DUNG

29d. DATE SIGNED (Month, Day, Year)

11 DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

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DHMN-16 Ray 1/89



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BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withings hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit, be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

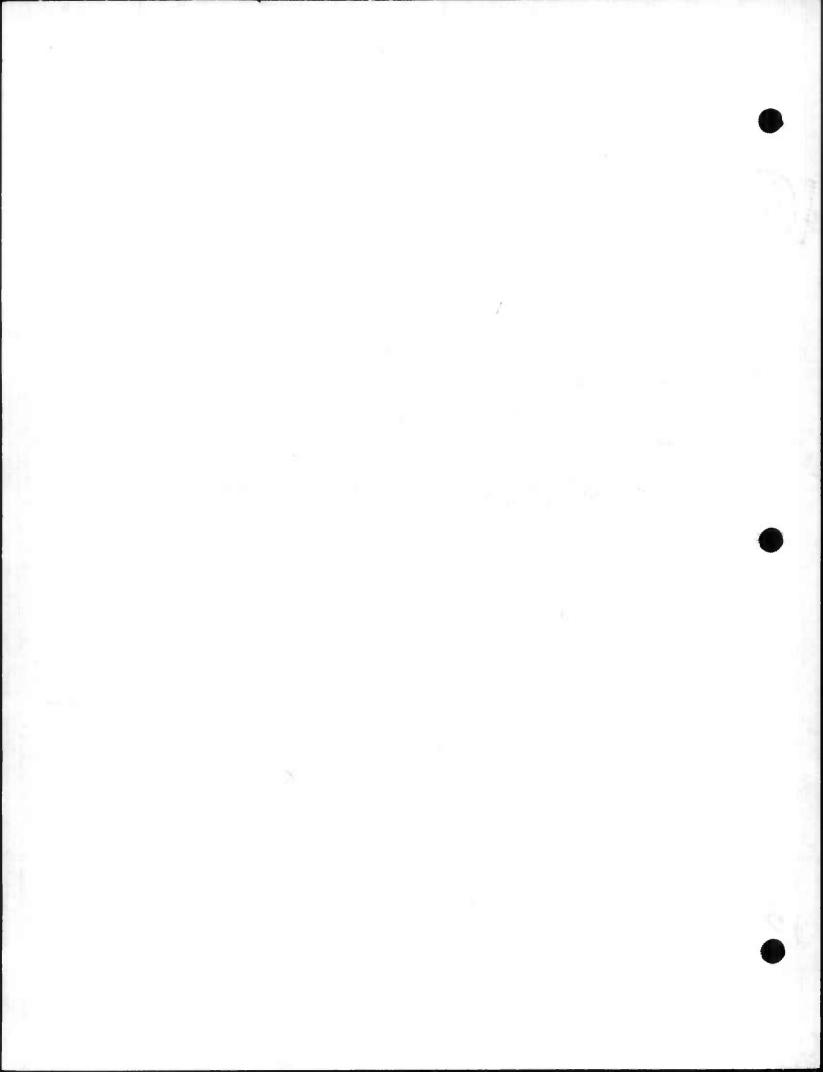
	1 - STATE REGISTRAR	SIAIE UP M	CE	RTIF	ICATI	OF	DEAT	AND N		TYGIEN REG. NO.			0	0
	1. DECEDENT'S NAME (First, Middle, Last)								2 DATE OF			VEAD	3. TIME OF DEATH	1
	Arthur L.	Schwenne							Jar		7	95	7:55 1	P. M
	4. SOCIAL SECURITY NUMBER 516-10-2163	5. SEX	6. AGE (In yrs. less 75	t birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF POPULATION OF PED.	BIRTH W Year) 1	010	8. BIRTH	HPLACE (State or Formity) tana	eign
	9a. FACILITY NAME (If not institution, give :		- 75	TNS.	9h CITY	TOWAL C	R LOCATIO	ON OF DE		1, 1		INTY OF D		
R	Hillhaven Nursi					le1pl		ON OF DE	AIII				George's	=
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT													
DIRECTOR	Maryland Princ	ce George	's	10c. C11	Adel		ION						10d. INSIDE CITY LIMITS? 1 YES 2	40
RAL	10s. STREET AND NUMBER					10f	. ZIP CODI						WHAT COUNTRY?	
FUNERAL	3005 Duncan Drive	12. WAS DECEDENT	EVER IN II S AD	MED	12	WAS DEC		783	IC ORIGIN? (S	M - M -			States	
	1 Never Married 2 Married	FORCES? X	YES 2 N	10	13.	Il yes, spi	ecity Cubin	n, Maxican	n, Puarto Rica	n, etc.)	or No—	Black Spec	E — American Indian	n,
19403 - 1970										White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY														
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 4 Civil Engineer 18. MOTHER'S NAME (First, Middle, Last) Talso IV. College (1-4 or 5 +) 18. MOTHER'S NAME (First, Middle, Maiden Surname)										t				
S S	17. FATHER'S NAME (First, Middle, Last)		1 011	7111	nig II.	CCI	18. MOTH	IER'S NAM	ME (First, Midd			2.1.0.17		
BE (Jake K. Schwenne	eker					Mar	-4	row					
5	19a. INFORMANT'S NAME (Type/Print) Anita M. Schwer	neker	196		ADDRESS as		nd Number	or Rural A	loute Number,	City or Town	n, State, Zij	p Code)		
	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION — City or Town, State											own, Stata		
	1 Donation 5 Other (Specify) Metropolitan Crematory Jan. 29, 1995 Alexandria, Virginia												irginia	
	22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, MD. 2												P.A.	705
	23. PART I. Enter the diseases, or	complications thet	caused the de	ath. Do i	not enter	the mo	de of dyi	ng, such	ea cerdiac	or reapi	ratory an	reat,	Approximat	te
	ahock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) a. TO STATE CUNC! NO MU												Onset and	
ļ	resulting in death)	. +10	STRITE	2 (U	CI	no	oma					mus	
_		OOE 10 (OR AS A CONSEC	DUENCE O	F):									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS A CONSEC	UENCE O	F):									
S	CAUSE (Disease or injury	C												
Ė	that initiated events resulting in deeth) LAST	DUE TO (OR AS A CONSEC	UENCE O	F):									
		d												
ICAL	PART II. Other significent condition	a contributing to	death but not re	suiting	in the un	derlying	cause g	iven in F		PERFOR	MED?	24b.	. WERE AUTOPSY FINE AVAILABLE PRIOR TO	0
MEDI						-			1	YES 2	NO		OF DEATH?	USE
. Z	DID TOBACCO USE CONT	RIBUTE TO CAL	ISE OF DEAT	TH YE	S \square I	VOV	LINC	ERTAIN					1 - YES 2 - NO	·]
IAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				TH (Check		0140	LKIAII		-				
PHYSICIAN:	1 TES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER		5 🗆 Re	aldence 6	Other (Sp	pecify)				
	27 MANNER OF OEATH 1 Setural 5 Pending	26a. DATE OF I (Month, Da		28b, TIM INJ	E OF JURY	28c. INJU	RK?		28d. OESCRI	BE HOW IN	NJURY OC	CUREO		
B	2 Accident Investigation	28a. PLACE OF	INJURY — At hor	ne, term.	street, tact	1 Y	7	\vee	28I. LOCATIO	N /Street o	and Number	o O Prival I	Pouts Mumbas	
COMPLETED	4 Homicide 6 Could not be determined	building, a	nc. (Specify)		,	7, 2,,,,,			City or To	wn, State)	a reampei	ST HUIGH P	ioste Humoei,	
PLE	29a. CERTIFIER Check only	CIAN: To the best of r	ny knowledge, des	ith occum	ed at the ti	me, data	and placa,	and due t	to the causels) and men	ner se stat	ted.		
MO		R: On the beals of ax											i) and manner as stat	ted.
w II	296. SIGNATURE AND TITLE OF CERTIFIE	MIN	1 00	X			29c. LICE	NSE NUMI	BER	r T	29d. DAT	E SIGNED	(Month, Day, Year)	
10 B	30 NAME AND ADDRESS OF BERSON WH	AMA	<u></u>	T			1))	-57)07	-	1	LMI	My 28,	144

OF DEATH NITEM 27) (Type, Print)

32 AEGISTRAR'S SIGNATURE Julia Davidson Rendall

1995

DHMH-16 Rev 1/89



32. MEGISTRAR'S SIGNATURES

02 1995

BALTIMORE, MARYLAND 21215-0029 the hospital ours after death. Page 6 may be retained by O. BOX 68760, DIVISION OF VITAL RECORDS,

Milbara (sali

長月

or attending 2 USB BS

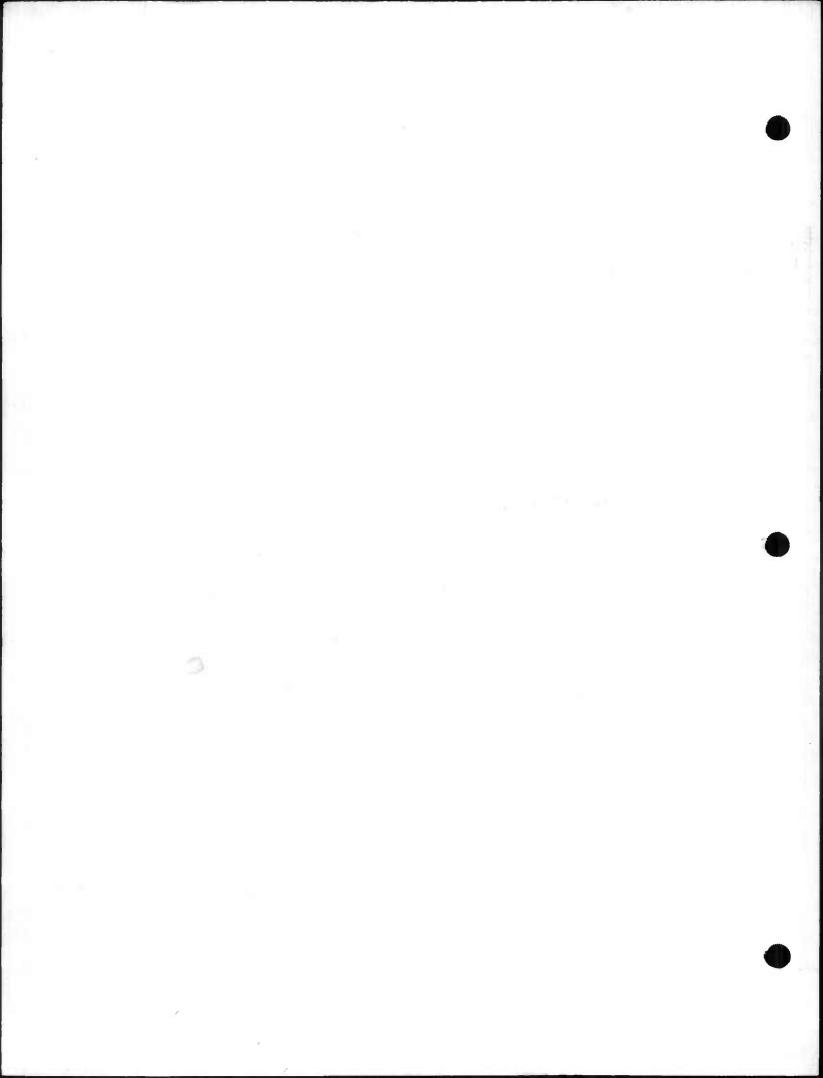
filled in by the funeral director, page 5 should be detached for ion, or removal. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within in and com to burial, the attending physician f Mental Hygiene prior to n signed by the Health and N

After death

0

completely filled inial, cremation, o

DHMH-16 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the fourts after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

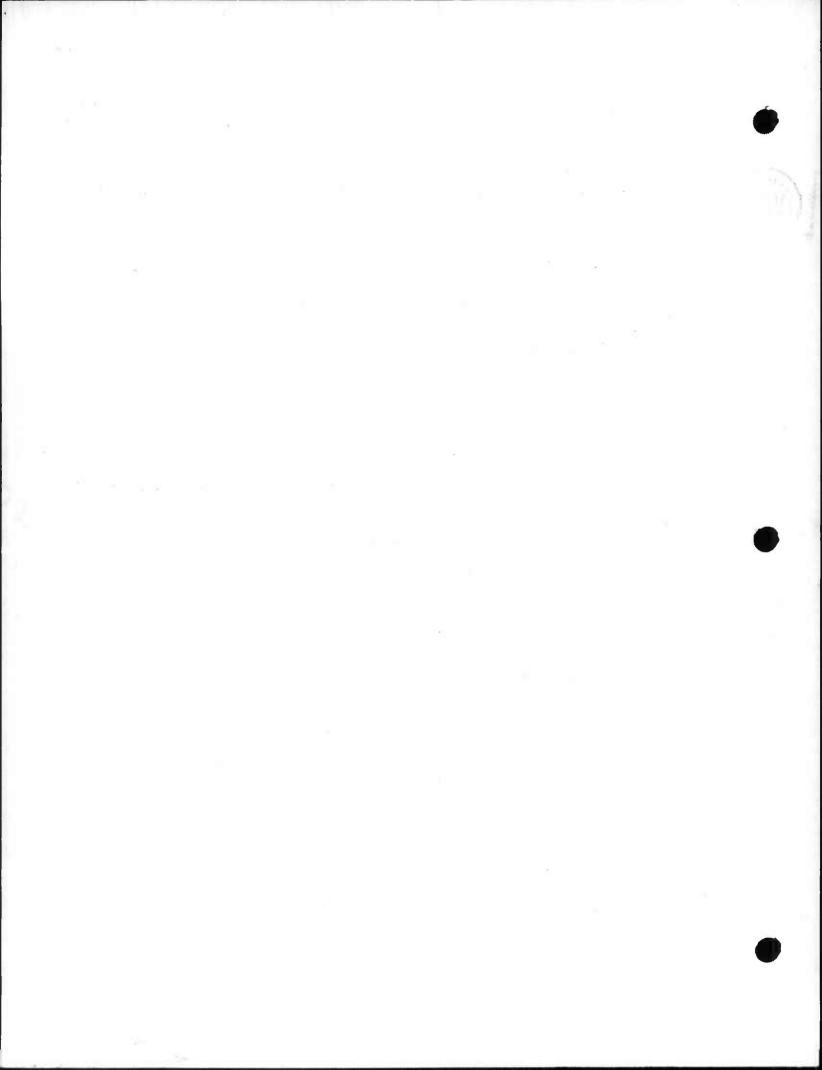
IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1				AT GI		R	ΑП
,	1.	DE	CE	OE	NT	'8	NA

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEOENT'S NAME (First, Mic	ddle, Last)	Ear1	C. Sh	arits			2. DATE O	F DEATH	AY	YEAR	3. TIME OF DEA	ATH
								Jan		8 1	955	10:35	P M
	4. SOCIAL SECURITY NUMBER		SEX	6. AGE (In yrs.		IF UNDER 1 YEAR	HOURS MIN.	(Month,	Day, Year)		Count		Foreign
	577-48-2782			83	YRS.			Marcl	15,				
œ	Pa. FACILITY NAME (If not institution, give street and number) Pernwood House Nursing Center Bethesda Montgomer												
FUNERAL DIRECTOR	RESIDENCE OF DECE	SE NUTS	sing Ce	nter		Bethe	sda			Mon	tgon	ery	
RE	10m. STATE 10	Db. COUNTY			10c. CITY	, TOWN OR LOC	ATION					10d. INSIDE CIT	Υ
□	MD Montgomery Bethesda 10											1 YES 2	NO
M.	10e. STREET AND NUMBER					1	Of. ZIP CODE			10g, CIT	ZEN OF V	VHAT COUNTRY?	
<u> </u>	5600 McLean		. WAS DECEDENT		. 195		20814				. S.	Α	
	1 Never Married 2 Mai		FORCES? 1	YES 2		If yes, s	CENDENT OF HISP pecify Cuben, Mex	ican, Puarto Ric	(Specify Year can, etc.)	or No-	Black	— American Ind c, White, atc.	llen,
B	3 Widowed 4 Divorced	d		II		1 4	S 2 X NO Spe	cify:			Spec	White	
	15. DECEDE (Specify only hig	ENT'S EDUCATI	ION noleted)	16a.	DECEDENT'S	USUAL OCCUPAT	ION poet of working	16b. I	IND OF BUS	SINESS/INC	USTRY	WILLE	
Elementary/Secondary (0-12) College (1-4 or 5 +) iiie. Do NOT use retired.)													
₽ E	5 + Accountant Internal Revenue Set 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)												e
		narits					1			Surname)			
H	19a. INFORMANT'S NAME (Type/				10h MARING	AODDESS (Street	and Number or Run	Clar		- 0	0.43		
2	Margaret Rap		arits				rive Be			2.08			
	20a. METHOD OF DISPOSITION			20b. PLAC	EANDDATEC	F DISPOSITION //	lame of		20c. LO			wn. Stata	
1 7	1 Burlal 2 Cremation 4 Donation 5 Donation	3 Ramoval ecify)	I from State	Ceda:	r Hill	Cemete	rv	1	Suit				ſD
	21. SIGNATURE OF FUNERAL SE	ERVICE LICENT	EE	-		22. NAME	ND ADDRESS OF	FACILITY JO	seph	Gaw1	er's	Sons	ш
	22. NAME AND ADDRESS OF FACILITY Joseph Gawler's So 5130 WI Ave. NW Washington, D.C.											2001	.6
	23. PART I. Entar the disea	saas, or com	plications that	caused tha	daath. Do n	ot anter tha m	oda of dying, se	Joh as cardia	c or reapi	ratory arr	eat,	Approxin	nsts
	shock, or haari iMMEDIATE CAUSE (Final	t fallura, List	t only one caus	se on aach li	na.							Interval E	
	disease or condition resulting in dasth)		Aspir	ation	pnemor	nia						1 wk	CAH
	DUE TO (OR AS A CONSEQUENCE OF): Cerebral vascular accident												
NO	Sequentially list conditions	b					ent					2 wk	
CERTIFICATION	if sny, leading to immediat cause. Enter UNDERLYING	ta	dysph	OR AS A CONS	EOUENCE OF):						2 wk	
윤	CAUSE (Disease or injury that initiated events	c		OR AS A CONS	EOUENCE OF):						Z WK	
E	resulting in death) LAST	d.	menta	1 stati	us cha	nge						2 wk	
	PART II. Other significant	conditions											
MEDICAL							ng causa given i		4a. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY F AVAILABLE PRIOR COMPLETION DF	OT S
ED	dementia,	prosta	ice_cano	er, ca	icnex1	1			YES 2	NO NO		OF DEATH?	CAUSE
	DID TOBACCO USE	CONTRIB	LITE TO CAL	ISE OF DE	ATH YE		T LINICEDTA					1 YES 2	NO
IAN	25. WAS CASE REFERRED TO MI	IEDICAL				H (Check only one			-				
PHYSICIAN:	EXAMINER? 1 ☐ YES 2 ☑ NO		OSPITAL:	ER/Outpetlant	3 🗆 DOA	OTHER:	ne 5 🗆 Rasidenc	8 🗆 Other (Specify)				
H	27. MANNER OF DEATH		28a. DATE OF (Month, Da		28b. TIME	OF 28c. IN	JURY AT ORK?	1	RIBE HOW II	NJURY OCC	UREO		
BY	1 Natural 5 Period	ding estigation					YES 2 NO						
	3 Suicide 8 Cou		28a. PLACE OF building, a	INJURY — At to. (Specify)	homa, tarm, a	treet, tactory, offi	ca	28f. LOCAT City or	ION (Street a Town, State)	nd Number	or Rural F	loute Number,	
COMPLETED		rmined											
뒽							and place, and d						
ő	2 MEOICAL	EXAMINER: O	on the basis of ax	amination and/o	or investigation	i, in my opinion,	death occured at ti	na time, data a	nd place, and	d due to th	e cause(s	and manner as	stated,
BE (29b. SIGNATURE AND TITLE OF	CERTIFIER	4	240	77		29c. LICENSE N					(Month, Day, Year)	
2	albert	Λ.	Lee	m			D 312	282		Ja	n. 2	9, 1995	
							thesda	MD 20	81/-2	107			
- 1	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Albert K. Lee, M. D. 8218 WI Ave. #105 Bethesda, MD 20814-3107												- 1
										-			
	31. OATE FILED (Month, Day, Year) FEB 01 10	")	32. REGISTRAF	R'S SIGNATURE				·		::			



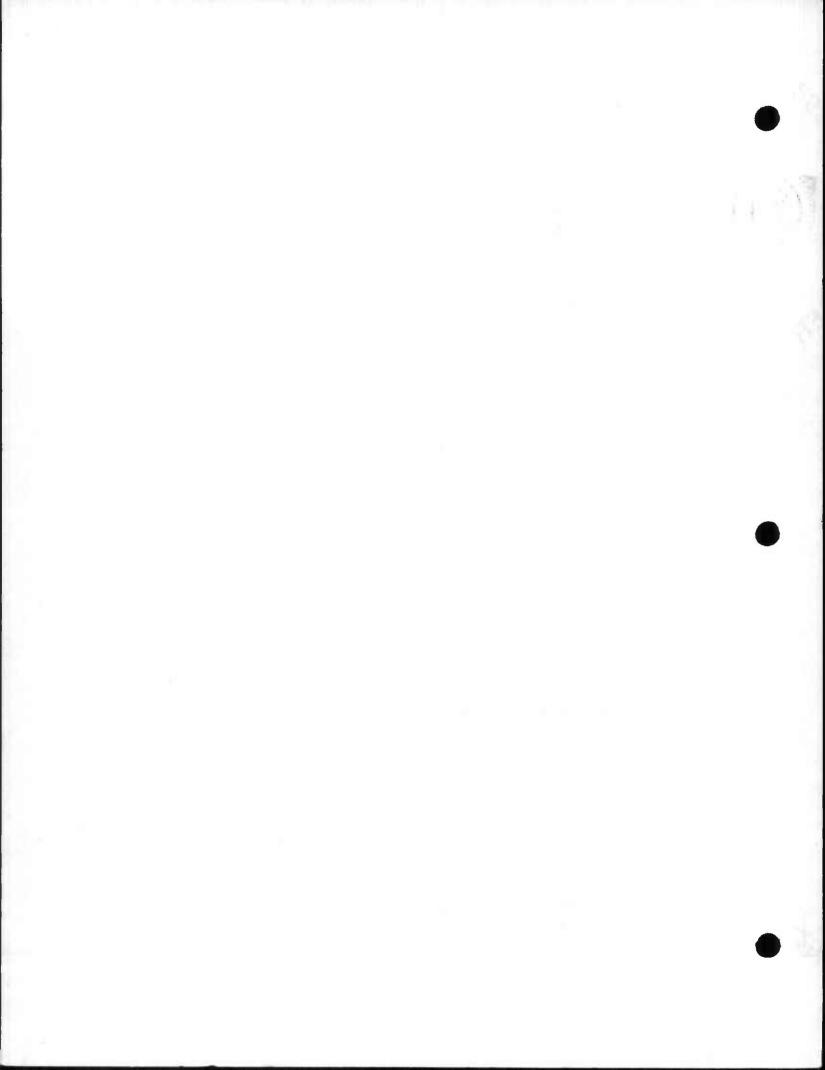


DIVISION OF VITAL RECORDS, P.O. BOX 68760.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within flours after death. Page 6 may be retained by the hospital or attending phys
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burning the find within 27 hours after death with the Clase Dear of Health and Mental Housen prior to burial committee of the montal
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAD

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR				CERTIF	ICAH	E OF	DEAL	Н	F	REG. NO.			
	1. DECEDENT'S NAME (First,	7 - 4 M			****					2. DATE OF MONTH	DEATH DA	ľ	YEAR	3. TIME OF DEATH
	Surriya	Ι.		eikh						Janua	ry 29	9, 19		12:40 A.M
	4. SOCIAL SECURITY NUMBE		5. SEX	6. AGE (In)	yrs. lest birthday)	IF UNDER	DAYS	IF UNDER	24 HRS.	7. DATE OF (Month, D.			8. BIRTH	IPLACE (State or Foreign
	217-80-7833		1 🗆 M 2 💢		56 YRS.	- Oltino	Jan. 1	Hooks	ariiq.				Pak	ristan
~	90. FACILITY NAME (If not ins							OR LOCATIO		EATH		9c. COU	INTY OF D	EATH
Q.	Washington		tist Hos	pital		'1	'akor	na Pa	rk			Mor	ntgon	nery
DIRECTOR	RESIDENCE OF DEC	10b. COUNTY			19c. CITY, TOWN OR LOCATION									10d. INSIDE CITY
H	Maryland	Princ	ce Georg	e's		olle								LIMITS?
-	10s. STREET AND NUMBER							f. ZIP CODI				10a CIT	IZEN OF V	WHAT COUNTRY?
18	8305 Potom	ac Ave	enue				- 1	2074				CHI	17 100	
FUNERAL	11. MARITAL STATUS		12. WAS DECEDER	IT EVER IN U.	.S. ARMED	13.	WAS DEC			HC ORIGIN? (S	oecity Yee	_	cista	
	1 Never Married 2 XX		FORCES?				Il yes, sp	Cube	n, Mexica	n, Puerto Rica	n, etc.)			E American Indian, k, White, etc.
BY	3 Widowed 4 Divon	ced						MAN NO	Opecin	,. 			Spec	<i>™</i> Asian
	15. DECE (Specify only	DENT'S EDUC	CATION completed)	16	Be. DECEDENT'S				v7	16b. KII	ID OF BUS	INESS/IN	DUSTRY	
9	Elementary/Secondary (0-		College (1-4 or 5		life. Do NOT us	se retired.)	daming mi		9					
M P	12			l	nomemak	er				p	civat	e		
COMPLETED	17. FATHER'S NAME (First, Mic	idle, Last)						18. MOTI	HER'S NA	ME (First, Midd	le, Maiden	Sumame)		
띪	Mohamed			_	Uma			Bi					Gu1	
6	190. INFORMANT'S NAME (Ty)		1. 2					and Number	or Rural I	Route Number,	City or Town	n, State, Zi	p Code)	
-	Islam M.		eikh		same	as	#10							
	20e, METHOD OF DISPOSITION 1 X Juriel 2 Cremation	ON 1 3 □ Remo	oval from State	comoto	ry, cremetory or o	ther piecel	1			OATE			City or To	
	4 Donalion 5 Other (Geor	ge Washi	natan	Cem	etery	Jan. 2	29,1995	Ade1	phi,	Maryl	and
	> 1 SIGNATURE OF FUNERAL	\\	ADOLL VILL	01		Dö 44	nala 00 F	owde	Borg r Mi	wardt 11 Rd	Fune Bel	ral tsvi	Home	P.A. Md. 20705
	23. PART I. Enter the dis	eeses, or c	omplifetions the	t caused th	he deeth. Do i									Approximata
	shock, or he	ert failure. I	List only one cer	use on eacl	h line.	iot oiltoi	i die inc	or or ayı	ng, auc	ii as cardiac	OI Teepi	ratory ar	rest,	interval Between
	iMMEDIATE CAUSE (Fine disease or condition	oi.	PA	JE WI	MON	14								Onset and Death
	resulting in death)	•			ONSEQUENCE O									40 DAYS
ا ہ					TICE		4							
<u>و</u>	Sequentially list condition if any, leading to immed		OUE TO	(OR AS A CO	ONSEQUENCE O		<u>'</u>							
CERTIFICATION	cause. Enter UNDERLYIN	IG	CNS		YMP	HO	MA	1						
<u> </u>	CAUSE (Disease or injur that initiated events		DUE TO	(OR AS A CO	NSEQUENCE O	F):								
	resulting in death) LAST		1											
	PART II. Other algorifican	t condition	contribution to	donth but	not moulting	in the se			-l l-	Deat I a			T	
EDICAL	PART II. Other alignitical	it conditions	s contributing to	death but	not resulting	in the ui	nderiyin	g ceuse (given in	Part I. 24	R. WAS AN PERFOR		246	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
اق										_ 1	YES 2	NO NO		OF DEATH?
Σ	DID TODA COO	1105 0	O) ITDIALIE											1 Y50 2 N 0
PHYSICIAN:	DID TOBACCO		ONIKIBUTE	10 0	AUSE OF	DEAI			NO	<u> </u>				
ᅙ	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:			OTHE		LACE OF D	EATH (Ch	eck only one)				
IYS	1 TYES 2 NO		1 Inpatient 2			4 🗆 Nu	rsing Hon		sidence	8 Other (S				
	1200000	ending	28e. DATE Of (Month, I		28b, TIM	E OF	W	JURY AT DRK?	6	28d. OESCR	BE HOW IF	NJURY OC	CUREO	
ĕ I	2 Accident Ir	rvestigation	OR- DI ACE (NE IN HIRW	A		1 🗆	7	NO					
8		could not be etermined	building	etc. (Specify)	At home, lerm,	street, fac	tory, offic	:0			own, State)	nd Numbe	r or Runal I	Route Number,
	20. CENTIFIED													
COMPLETED			CIAN: To the best o											
ğ	2 MEDIC	AL EXAMINE	R: On the basis of a	samifation e	nd/or investigation	n, In my	opinion, (death occur	ed at the	time, date en	f place, en	d due to t	he cause(e) end menner es stated,
BE	29b. SIGNATURE AND TITLE	OF CERTIFIER	12/5	Che				29c. LICE	NSE NUI	MBER		29d, DA1	TE SIGNED	(Month, Day, Year)
10 B			11/XC	0)				72	29	10		トフ	AN,	2917,1995
F	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAL				DUS	E RI	0.0	OHEC	ie i	PIC.	· N	1020740
	31. DATE FILED (Month, Day, Y	bar)	32 MEGISTR	AR'S SIGNATI		* 1		. ,	,		- 1		•	790
	JAN 3.	1 1995	Julia di	nesteen	Mardall									1



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BALTIMORE, MARYLAND 21215-0020

DIRECTOR

FUNERAL

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Page 6 may be retained by the hospital or attending physician al director, page 5 should be detached for use as the burial-tra funeral director, page 5 should be detached for ä notified e e must the medical examiner death. signed by the attending physician and completely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal. event, THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed with THE FUNERAL DIRECTOR: After this certificate has been signed by the attenting physician and competer filed within 72 hours after death with the State Dept. of Health and Mental Hydiene orior to hurial resem traumatic or other апу shows a 23 10 marked, 49 28 Item FUNERAL within 72 1 TO THE HOSPITA
TO THE FUNERAL
BE filed within 72
IMPORTANT: II

CERTIFICATION

MEDICAL

PHYSICIAN:

ВҮ

COMPLETED

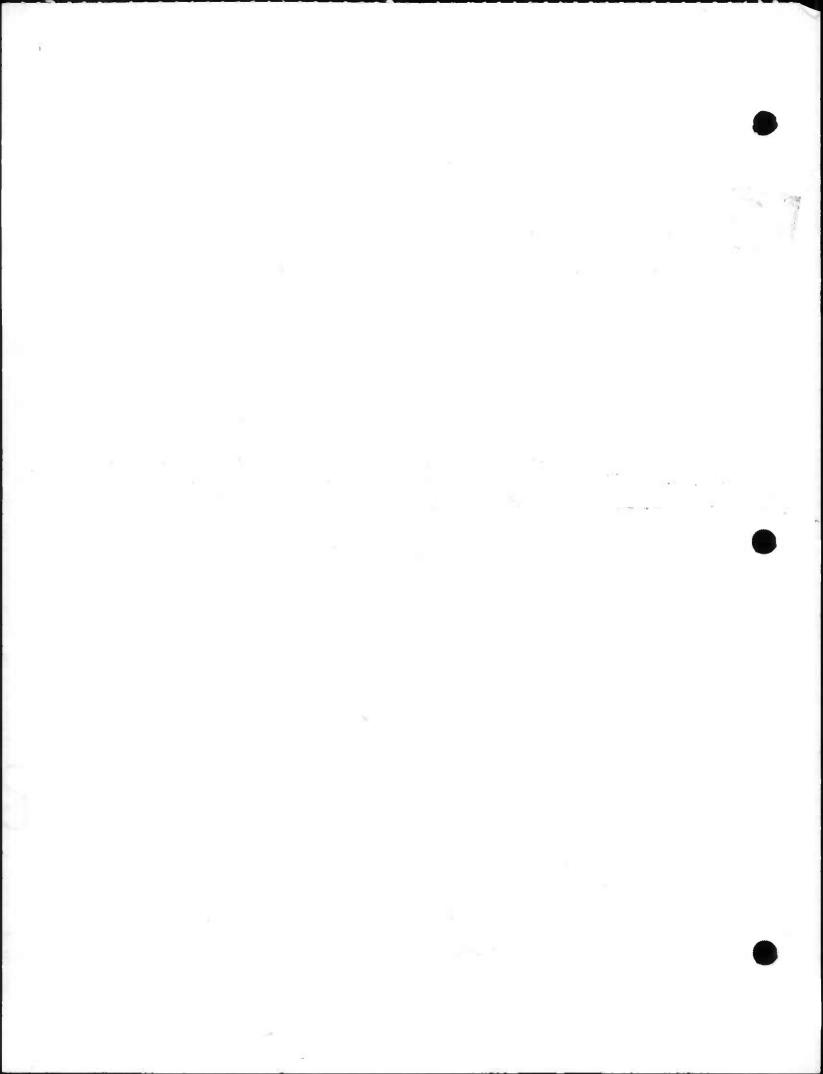
TO BE

31. DATE FILED (Month, Day, Year)

1995

DIVISION OF VITAL RECORDS, P.O. BOX 68760

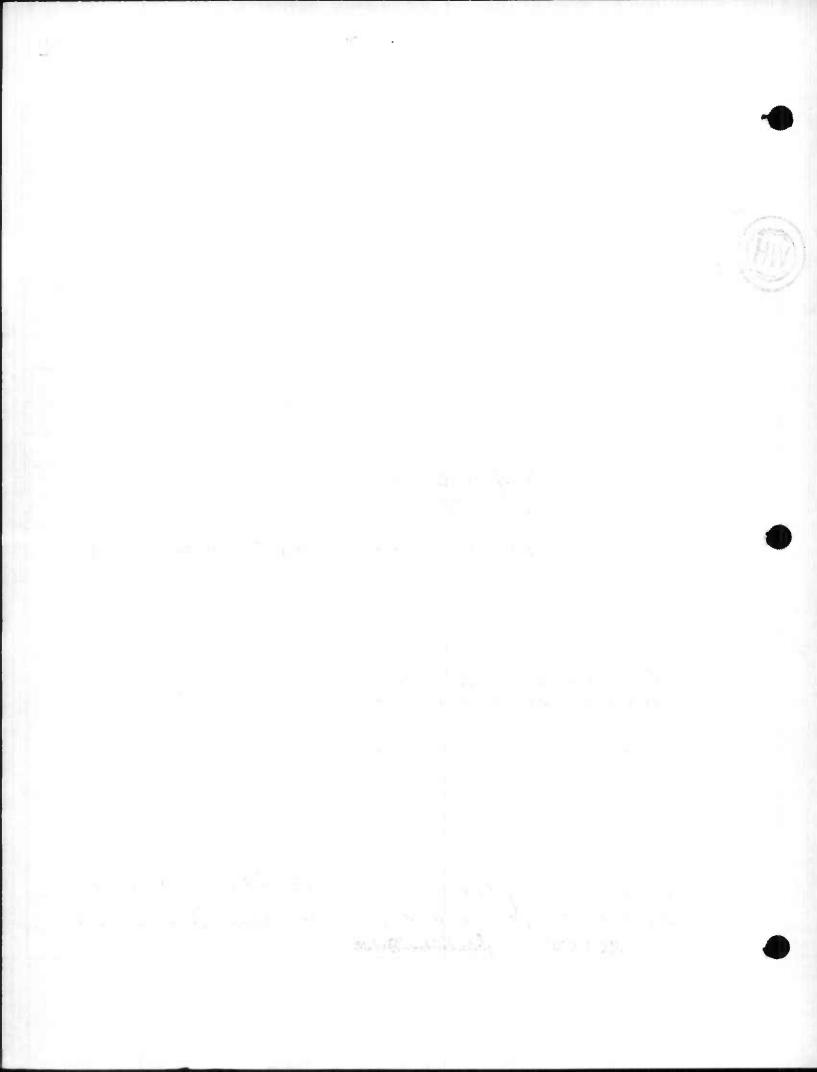
CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Anna Ella Salter January 25 6:10 A SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 214-03-9369 DAYS HOURS MIN. t M 2 X F Virginia YRS. Aug. 19, 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Holy Cross Hospital Silver Spring Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Montgomery Silver Spring 1 TES 2 X NO 10e. STREET AND NUMBER 10f. ZIP COOF 10g. CITIZEN OF WHAT COUNTRY? 12105 Grandview Avenue 290 20902 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexicen, Puerto Ric 1 ☐ YES 2 🔯 NO Specify: 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES SpecMy: White 3 🛛 Widowed 4 🗌 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Supervisor Restaurant 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Joseph H. Nicholson Grace Worthington 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) James H. Salter 4600 Bettswood Drive Olney, Maryland 20832 20e. METHOD OF DISPOSITION
1 St Buriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE George Washington Cemetery 1/30/95 Adelphi Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr. MD 20901 amuel ha daath. Do not antar the moda of dying, such as cardiac or reapiratory screet, 23. PART I. Enter the disesses, or complications that cause shock, or haart failure. List only one cause of Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) reek DUE TO (OR AS A CONSTOUENCE OF Sequantially list conditions, if any, lasding to immediata cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 - YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🗷 NO 🗌 UNCERTAIN 🗌 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 A Inpatient 2 ER/Outpatient 3 DOA 1 YES 2/NO 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DEȘCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO Investigation Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, offica building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide determined 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(a) and manner as stated. 296. SIGNATURE AND THE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2309



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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OF ALLINOING FILLS OF THE SAY REQUIRES THAT THE DESCRIPTIONS OF EXCLUSION WITHIN 24 HOURS SIGN DESCRIPTION OF IREST.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5:		
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THE COLUMN	pletely	hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	
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	1 - FOR STATE REGISTRAR	STATE OF M			TMENT CATE					HYGIEN REG. NO.	_		
	1. DECEDENT'S NAME (First, Middle, Last) John Alvin Thomp	gon							2. DATE OF MONTH Janua	DEATH D		YEAR	3. TIME OF DEATH 0630 hrs M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	it birthday)	IF UNDER	1 YEAR	IF UNDER	R 24 HRS.	7. DATE OF	BIRTH	199	8. BIRTHE	LACE (State or Foreign
	213-05-5783 90. FACILITY NAME (If not institution, give si	86	YRS.	MONTHS	DAYS	HOURS	MIN.	May 15	, 190		Mary	Land	
E C	Pats Domicillary						vill	ON OF DE	ATH			nty of de	
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY			1 22 22				.С			lyuee	II AIII	
DIRECTOR		ueen Anne	es	10c. CIT	LIMITS?						10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	1202 Goldsboro R					101	. zip cod 21	.607					tates
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1	MAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO FYES, GIVE WAR OR DATES			13. WAS DECENDENT OF HISPAN If yes, specify Cuban, Mexican 1 YES 2 NO Specify				ANIC DRIGIN? (Specify Yes or No— 14. RAC Blac an, Puerto Rican, stc.) Specify:			— American Indian, White, atc. :: Vhite
9	15. DECEDENT'S EDUC (Specify only highest grade		16a. DE	CEDENT'S	USUAL OC	CUPATIO	ON at of world	na	16b. KII	ND OF BUS	SINESS/INC		
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	- iiia	Do NOT u	ente:		at or works			Voodv	vork		
ő.	17. FATHER'S NAME (First, Middle, Last)		1				18. MOT	HER'S NAM	ME (First, Midd	lle, Meiden	Sumame)		
BE (John Wesley Thom	pson							Valina				
10	190. INFORMANT'S NAME (Type/Print) Barbara Everett		194	b. MAILING					e 300				Maryland
	20a. METHOD OF DISPOSITION 1X Burlel 2	ovet from State	20b. PLACE /	AND DATE	OF DISPOSI	TION (Na	me of		OATE	20c. LO	CATION -	City or Ton	n State
	21. SIGNATURE OF FUHERAL BERVICE LIC	ENSE A	4N	VILLE	22.1	NAME AN	D ADDRE	SS OF FAC	YTLIN			Je, M	aryland
	▶ William L. K	ing Jr.	of Zen	19					1 Home			on N	Maryland
	23. PART I. Enter the diseases, or c ahock, or heart feilure. I	omplications that	caused the de	ath. Do r	not enter	the mo	de of dy	ing, auch	as cardiac	or reapi	ratory arr	eat,	Approximata
	iMMEDIATE CAUSE (Final disease or condition reaulting in death)	Arx	lerios	1	107	L ,	14	3AL	7 7) IS e	W.		Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEC	DUENCE O	F): F):								
MEDICAL	PART II. Other eignificent condition	contributing to a	me h	JA	in the un	derlying	ceuse (given in F		e. WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
			11 -00	1					-				1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:					ACE DF D	EATH (Che	ck only one)				
YSI	1 TES 2 THE	1 Inpatient 2 I				r: Ing Home	5 🗆 Re	esidence (6 Other (S)	oecify)			
ву РН	27. MANNER OF DEATH 1 Descript 5 Pending 2 Accident Investigation	28a. DATE OF II (Month, Day		28b. TIM INJ	E OF URY M	26c. INJU WOS 1 Y			26d. DEŞCRI	BE HOW II	NJURY OCC	CURED	
	3 Suicide 6 Could not be determined	26e. PLACE OF building, e	INJURY — At her	me, ferm, s	street, facto	ory, office)		28f. LOCATIO	ON (Street e own, State)	nd Number	or Rural Ro	ute Number,
COMPLETED	290. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC (Check only one) 2 MEDICAL EXAMINES												and menner as stated.
BE	29b. SIGNATORE AND TITLE DE CENTIFIER)				29c, LICI	SE NUM	BER QQ		29d. DATE	E SIGNED (Month, Day, Year)
5	30. NAME AND ADDRESS OF PERSON-WHE	CDMPLETEO CAUSE	OF DEATH (ITE	M 27) (Type,	Print)	h	0 ()	end	00	1	0	711	2 1
10	31. DATE FILED (Month, Day, Year) JAN 13 'Q	32. REGISTRAR	s signature	son-A	andall	2	20		- In In	FV	- DX		, <u>C</u> V



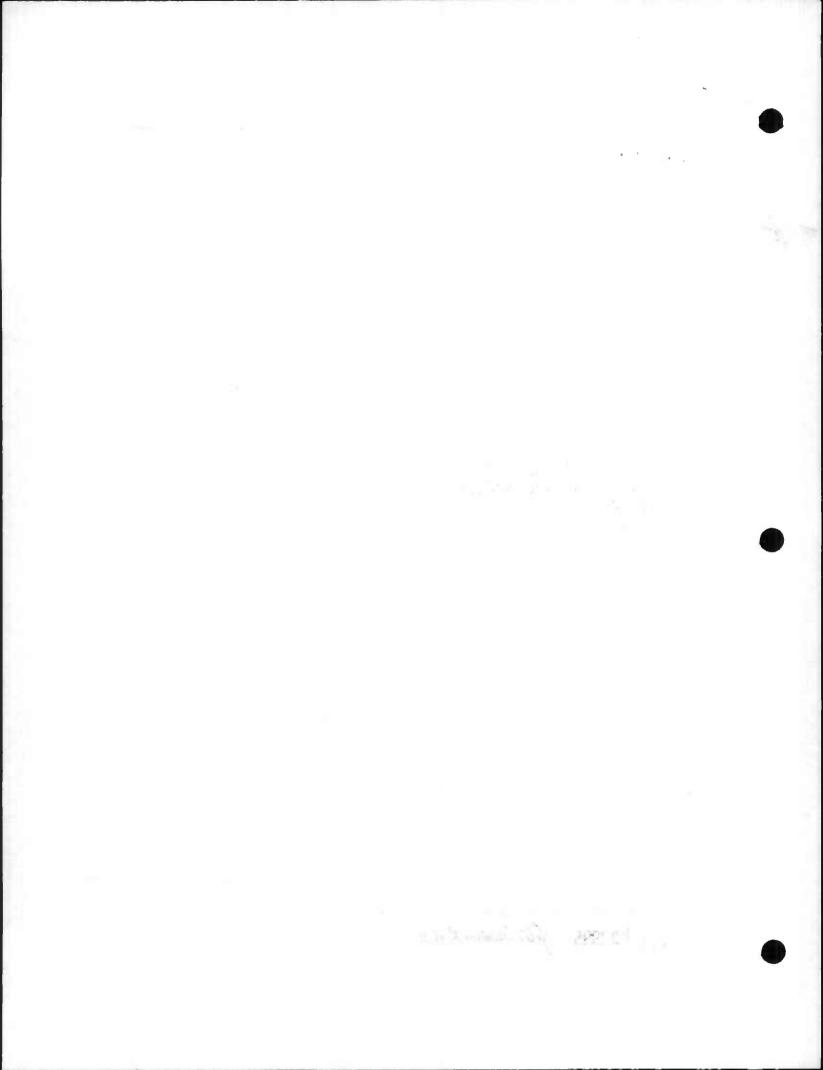
BALTIMORE, MARYLAND 21215-002

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DIVISION OF VITAL RECORDS, P.O. BOX 6876	OD ATTENDIAD BUINDIAM: The face show that the death
Property Co.	

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_	1 - FOR STATE REGISTRAR	STATE OF MA	RYLAND /	DEPAR	TMENT (F HEALTH	AND I		IYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF	DEATH			3. TIME OF DEATH
1	MARY CHILCOAT	TURNER						Febru	יויר ב		YEAR	77.70 - 4
	4. SOCIAL SECURITY NUMBER	5. SEX 8.	AGE (In yrs. les	t birthday)	IF UNDER 1 Y	EAR IF UNDE	R 24 HRS.	7 DATE OF	DIDTH			11:10 a M PLACE (State or Foreign
	213-48-6138	1 M 2 X F	74	YRS.	MONTHS D	AYS HOURS	MIN.	Dec. 6	y, Year) 9	20	Mar.	yland
	9a. FACILITY NAME (If not institution, give str	eet and number)			9h CITY TO	WN OR LOCAT	ION OF D		, _,	_	NTY OF DE	
Œ	CREAMED DAIMSTOOD MEDICAL CONTRACTOR											
I R	RESIDENCE OF DECEDENT	ORE MEDICA	AL CENT	PER	TO	WSON				BALT	rIMOR.	E
DIRECTOR	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR I	OCATION						10d. INSIDE CITY
=	Maryland Balt	imore		M	onkto	onkton						LIMITS?
A L	10e. STREET AND NUMBER					10f. ZIP COD	Œ			10g. CIT		HAT COUNTRY?
FUNERAL	1418 Corbett	Road					211	11			.S.A	
3	11. MARITAL STATUS	12. WAS DECEDENT EV	VER IN U.S. AR	MED	13. WAS	DECENDENT	OF HISPAN	NIC ORIGIN? (S	pecify Yea		14 BACE	- American Indian
	1 Never Married 2 Married	FORCES? 1	YES 2 X N	10	If yo	YES 2 X NO	an, Maxica	in, Puerlo Rice	n, atc.)		Black,	White, etc.
ВУ	3 🔀 Widowed 4 🗌 Divorced	0.0000 1.00000				122 22	ороон	,.			эриспу	White
	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION completed)	16a. OE	CEDENT'S	USUAL OCCU	PATION	ina	16b. KI	ID OF BUS	SINESS/INC	DUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)				ng most of worki						
MP	4		Re	gis	tered	Nurs	е					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	al-11						ME (First, Midd				
BE	Samuel Mortime	r Chiled	pat			Ar	mide	e Cou	rtne	y W	ilso	n
TO	19a. INFORMANT'S NAME (Type/Print)					reet and Numbe						
-	Courtney T. Ri	tzmann	1	418	Corb	ett R	d.,	Monk	ton,	MD	211	11
	20a. METHOD OF DISPOSITION 1 Durial 2 Cremation 3 Remove	rel from State	20b. PLACE A	ND DATE	F DISPOSITIO	N (Name of	o Tile	- OAJE	20c. LO	CATION -	City or Tow	n, State
1	4 Donation 5 Other (Specify)		Episco	opa I	Ceme	H Jame tery	SIE	1995'	Mo	nkto	on, I	MD
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE .		***	22. NAI	E AND ADDRE	SS OF FA	CILITY				
	* XX XX	tenston	1		24	. Har	ten:	stein	Mor	tua	ry,	Inc. A 17349
Н	23. PART VEnter the diseases, or co	mplications that ca	used the de	eth Don	ot enter the	mode of dy	ing such	h as cardiac	or soonly	edon	l, Pr	Approximate
ш	interval Between											
1 1	disease or condition	0	7 Head to mas					_				Onset and Death
1 1	disease or condition resulting in death) . Congettive Heart Failure Due to (or as a consequence of): CARNION YOFATIAY GYEAR								_			
-		CARNI	O ha le	~ PI	ATIAN							V
RTIFICATION		DUE TO (OR	AS A CONSEC	UENCE OF):							odeni
¥	if any, leading to immediate cause. Enter UNDERLYING											i '
표	CAUSE (Disease or injury that initiated events	DUE TO (OR	AS A CONSEQ	UENCE OF	·):							
F	resulting in death) LAST											
뜅	U.											+
A L	PART ii. Other algnificent conditiona	contributing to des	ith but not re	suiting i	n the under	lying ceuse	given in	Pert i. 24s	. WAS AN			VERE AUTOPSY FINDINGS
EDICAL								10	YES 2			COMPLETION OF CAUSE OF DEATH?
ME						,						YES 2 NO
	DID TOBACCO USE CONTRI	BUTE TO CAUS	E OF DEAT	ГН ҮЕ	S NC	UNC	ERTAIN	<u> </u>				
N SI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE	E OF DEAT	H (Check only	one)						
Sic		HOSPITAL:	Outpatient 3	□ DOA	OTHER:	Home 5 🗆 Re	esidenca	5 ☐ Other (Sc	ecify)			
PHYSICIAN:	27. MANNER OF DEATH	26a. OATE OF INJU		26b, TIME	E OF 260	. INJURY AT		28d. DESCRI		JURY OCC	CURED	
ВУ	1 Natural 5 Pending 2 Accident Investigation	(MOTRIX, Day, II	our)	INJ		WORK?] NQ					
	3 Suicide 8 Could not be	28a. PLACE OF IN- building, etc.	JURY At hon	na, farm, a	treet, factory,	office		26f. LOCATIO	N (Street a	nd Number	or Rural Ros	ute Number,
TED	4 Homicide determined	building, etc.	(Specify					City or To	wn, State)			
MPLET	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICI	AN: To the best of my	knowledge, des	th occurre	d at the time	date and place	and due	to the course	and man		-4	
M	(Check only one) 2 MEDICAL EXAMINER:											and manner or state d
00	29b. SIGNATURE AND TITLE OF CERTIFIER		ATTIC MEETING		,				prove, ent			
뮒	SOUND AND THE OF CERTIFIER	Time a	. 1			29c. LICI	ENSE NUM	BER		29d. DATE	SIGNED (A	Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE =	E DEATH #===	1 0 T	O-F-Al		D	100			V(2	171
	TAL PT RI	1 12 16	P DEATH (ITEM	27) (Type.	Print)	11/-0	10	Mr.	.1/-	J. A	1 5	Many
	1.200 131	2013-	-ma)	15	ال ال	71 1 GKC	IR	100	N 01	7, ~	5	L 000 J



BALTIMORE, MARYLAND 21215-0020	4 hours after death. Page 6 may be retained by the hospital or attending physician.	illed in by the funeral director, page 5 should be detached for use as the burial-transit n, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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·	1 - FOR REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF	F HEALTH AND	MENTAL HYGIEN			
		THOMPSON				February 2	, 19	YEAR	7:30 A M
8	215-68-8239	1 M 2 R F	83 yrs.	MONTHS DAY		May 17,19	11	8. BIRTHP	LACE (State or Foreign
OR	98. FACILITY NAME (If not institution, give street Shady Grove Advent		1]		whor location of d		9c. COU	INTY OF DE	
בו	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY								
L DIRECTOR		gomery		ithers!	ourg				IOd. INSIDE CITY LIMITS? I TYES 2 NO
FUNERAL	213 Washington Gro				20877		117	ted S	tates
ВУ	11. MARITAL STATUS 1 Never Married 2 Merried 3 V. Wildowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 _ YES IF YES, GIVE WAR OR D.	NUS, ARMED 2/XNO ATES	If yes	DECENDENT OF HISPA , specify Cuben, Mexico YES 2 , NO Specific		e or No	Black,	- American Indian, White, etc. White
COMPLETED	16. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S (Give kind of a life. Do NOT us Homema	work done during se retired.)	ATION a most of working	Own Ho		DUSTRY	
S.	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Meider			
BE (Ernest L. Fraley	/			Daisy	Allnutt			
TO	Janet D. Manuel					Route Number, City or Tov ithersburg			20877
	20s. METHOD OF DISPOSITION 1 Description 1		PLACE AND DATE etery, cremetory or o prest Oal	k Cemet	ery	2/6 Gai		city or Tow sburg	, state , Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICEN MULLIP	Barker)	Muri		cum ber Funera <u>ville Road</u>			20882 ville Md
	23. PART I. Enter the diseases, or corshock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death)	mplications that cause of st only one cause on a	the desth. Do reach line.	not enter the	mode of dying, suc	h as cardlec or reap	iratory sr	reat,	Approximate interval Batween Onset and Daeth Mins
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST		CONSEQUENCE OF						day
PHYSICIAN: MEDICAL (PART II. Other significant conditions of	contributing to death b	ut not resulting	in the underl	ying cause given in	Part I. 24e. WAS AMPERFO	PMED?	0	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? YES 2 NO
ä	DID TOBACCO USE CONTRIE	BUTE TO CAUSE O	F DEATH YE	S 🗆 NO	☐ UNCERTAI	N D			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) OTHER: 1 Inpetient 2 VER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)									
ВУ РН									
ED	2 Accident Investigation 3 Suicide 8 Could not be determined	28e, PLACE OF INJURY building, etc. (Spec	— At home, farm, a	street, factory, o	ffice	28f. LOCATION (Street City or Town, Stete	end Number	r or Rural Roo	ute Number,
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL EXAMINER: (Check only one) 2 MEDICAL EXAMINER: (Check only one)	AN: To the best of my knowl							
	296. SIGNATURE AND TITLE OF CERTIFIER		IIITVINGBIIO	, my opinio					
BE	teven H.	Gevas.	MI)		1) 29 LICENSE NUI	647	29d. DAT	E SIONED (A	Month, Day, Year)
2					0-1	70	1	SD 4	77/177

Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initisted events resulting in deeth) LAST	a	DUE TO (OR AS A CONSEQUENCE OF):	
	d	DUE TO (OR AS A CONSEQUENCE OF):	
PART II. Other significant cond	ltione con	tributing to death but not resulting in the underlying cause given in Part i.	24a. WAS AN AUTOPSY PERFORMED?

		Total of Destrict Involves only								
1 YES 2 NO	HOSPITAL: 1 ☐ Inpatient 2 N ER/Outpatient 3	DOA 4	OTHER:	6 ☐ Other (Specify)						
MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME (28d. DEŞCRIBE HOW INJURY OCCURED						

2 MEDICAL EXAMIN	NER: On the basis of examination and/or invest	ligation, in my opinion, death occursd at the time, date e	nd place, end due to the ceuse(e) end manner es s
SIGNATURE AND TITLE OF CERTIFI	ER	290 LICENSE NUMBER	29d. DATE SIONED (Month, Day, Year)

132. RECHTRAR'S SIGNATURE

4. 4 Sa.

DIRECTOR

FUNERAL

BY

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COMPLET

BE

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funeral director, page 5 should be detached for use as the burial-transit

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CERTIFICATION

PHYSICIAN: MEDICAL

BY

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been signed by the attending physician and completely filled in by the it. of Health and Mental Hygiene prior to burial, cremation, or removal.

has by Dept.

After this certificate death with the State

DIRECTOR: /

TO THE FUNERAL OF THE FUNERAL OF THE WITHIN 72 PO IMPORTANT: If II HOSPITAL

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the death certificate be

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ATTENDING PHYSICIAN: The law

В

DIVISION OF VITAL RECORDS, P.O. BOX 68769

retained by the hospital or attending physician.

hours after death. Page 6 may be

BALTIMORE, MARYLAND 21215-0020

REGISTRAR		CERTIF	FICATI	E OF	DEA	ГН	REG. NO.			
Joseph Mique	1		To	RRE	5.	Jr.	2. DATE OF DEATH MONTH DA	21 1	YEAR 995	3. TIME OF DEATH
BOCIAL SECURITY NUMBER 25-01-8520	5. SEX 1 M 2 F	6. AGE (In yrs. lest birthday) 82 YRS.	IF UNDER	DAYS	IF UNDER	24 HRS.	7. DATE OF BIRTH (Morth, Day, Year) 12/29/1912	- ,	B. BIRTH Countr	PLACE (State or Foreigy)
FACILITY NAME (If not institution, give at	reet and number)		9b. CITY	, TOWN	OR LOCATI	ON OF D			NTY OF D	EATH
ENTINSULA REGIONA	L MEDICA	L CENTER		SAT	TSBII	RY		WT	COMT	CO

10b. COUNTY

10c. CITY, TOWN OR LOCATION

10d. INSIDE CITY

Maryland Worcester 10e. STREET AND NUMBER

Pocomoke City

TY YES 2 NO 10g. CITIZEN OF WHAT COUNTRY?

USA

105 Hampshire Terrace 11. MARITAL STATUS

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES

21851 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puerto Rican, atc.) 1 YES 2 NO Specify:

14. RACE — American Indian, Black, White, etc. Specify:

1 Never Married 2 Married 3 Wildowed 4 Divorced

15. DECEDENT'S EDUCATION (Specify only highest grade completed) College (1-4 or 5+) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)

White 16b. KIND OF BUSINESS/INDUSTRY

11

17. FATHER'S NAME (First, Middle, Last)

Bulp Mill Superintendent

Paper Mfg. Co.

Joseph Miguel Torres, Sr.

Louise Moore

16. MOTHER'S NAME (First, Middle, Maiden Surname)

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Pocomoke City, Md.

19a. INFORMANT'S NAME (Type/Print) Arnold Torres

105 Hampshire Terrace, 20b. PLACE AND DATE OF DISPOSITION (Name of

OATE 20c. LOCATION - City or Town, State Georgetown, S.C.

4 Donation 5 M Other (Specify) Intermement 21. SIGNATURE OF FUNERAL SERVICE LICENSEF

ennymoval Mem. Gardens Mausoleum | 2/4 22. NAME AND ADDRESS OF FACILITY

Melson Funeral Home PO BOX 64, Pocomoke City, Md. 21851

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart fellure. List only one couse on each line

Approximate intervai Between

IMMEDIATE CAUSE (Finel disease or condition_ resulting in deeth)

ementila

DUE TO (OR AS A CONSEQUENCE OF)

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, If any, leading to Immediate cause. Enter UNDERLYING CAUSE (Diseese or injury that initiated eventa resulting in death) LAST

PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 12/94

24a. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | NO

Onset and Death

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN

25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) 1 YES 2 NO

HOSPITAL OTHER: Inpetient 2 - ER/Outpatient 3 - DOA

g Home 5 - Residence 8 - Other (Specify) 26d. DESCRIBE HOW INJURY OCCURED

27. MANNER OF DEATH 1 Matural 5 Pending investigation 2 Accident

8 Could not be

28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c, INJURY AT

1 YES 2 NO 28s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 [MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

PERSON WHO PLETEO CAUSE OF OEATH (ITEM 27) (Type, Print)

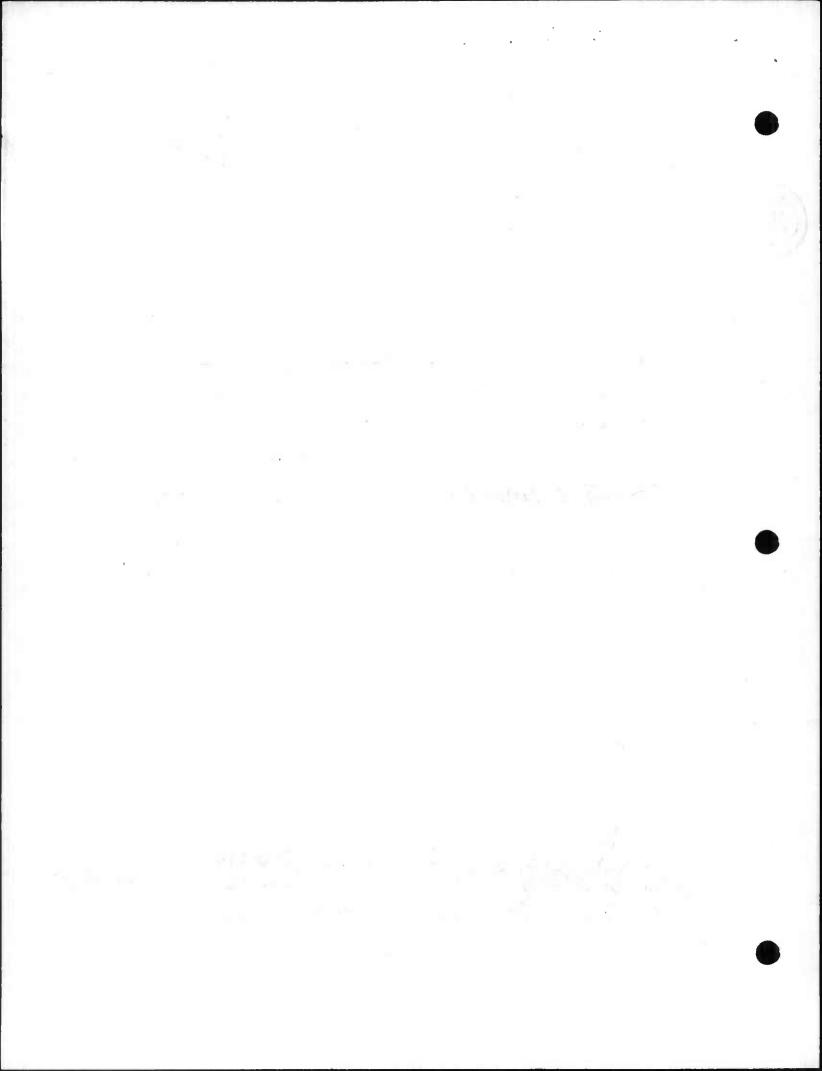
AUSbury

31. DATE FILED (Month, Day,

32. REGISTRAR'S SIGNATURE

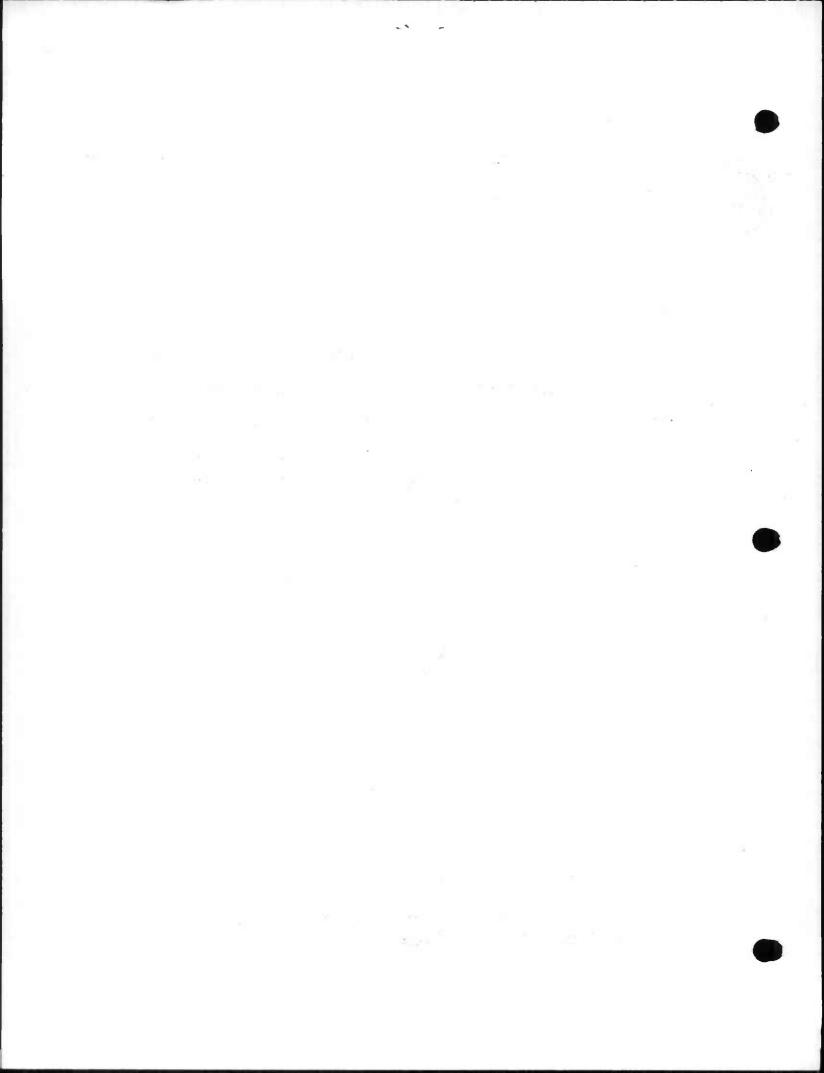
204 A

29d. DATE SIGNEO (Month, Day, Year)

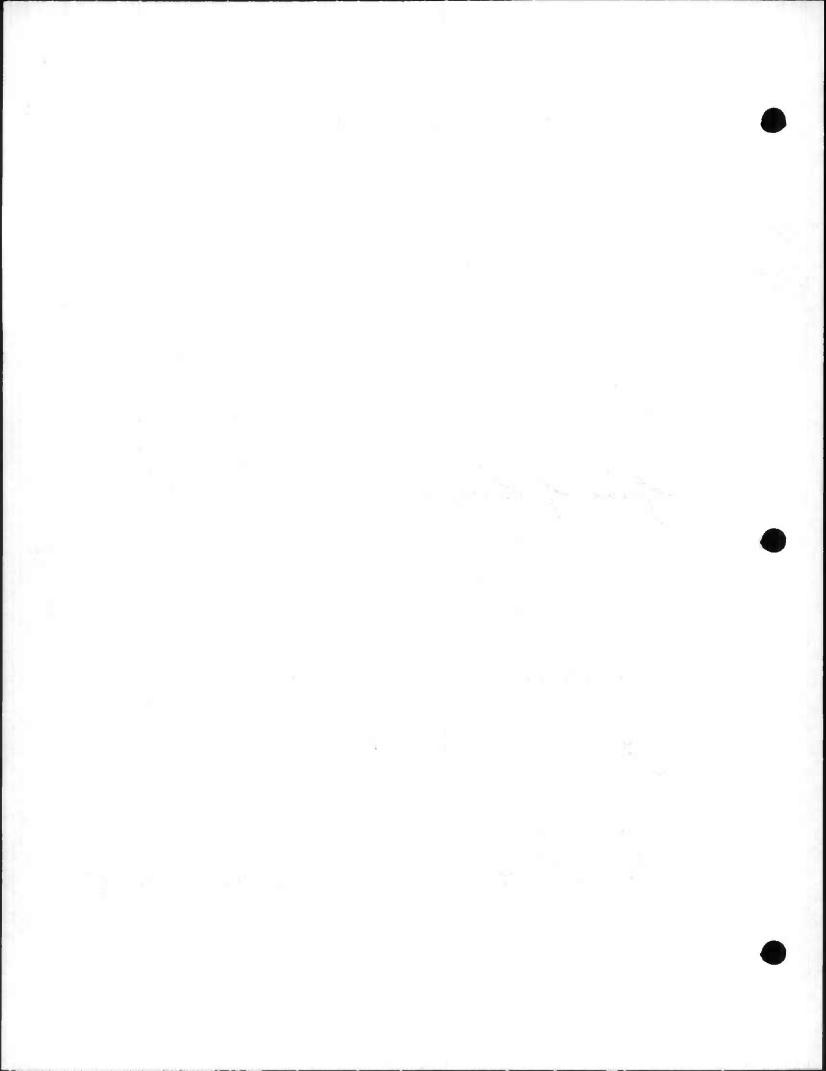


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	DR A	DIREC	hours	Item	
	PITAL	ERAL	in 72	II: H	
	E HOS	E FUN	d with	RTAN	
	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within anous after death. Page 6 may be retained by the hospital or attends	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - STATE STATE OF MA	RYLAND / DEPAR CERTIF	TMENT OF HEALTH	AND MEI	NTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Lest)			2.	DATE OF DEATH	YEAR Y	3. TIME OF DEATH
	ETHEL M.		Tull		ebruary	1 1995	1:35 PM M
R I		AGE (In yrs. lest birthday)	IF UNDER 1 YEAR IF UNDER MONTHS DAYS HOURS	90194	DATE OF BIRTH (Month, Day, Year)	f Cour	
	218-10-0073 1 M 2XXF 9s. FACILITY NAME (If not institution, give street end number)	100 YRS.		A	UG. 12, 1		ARYLAND
m I			9b. CITY, TOWN OR LOCAT	ION OF DEATH		9c. COUNTY OF	
2	Memorial Hospital at Easto	n	Easton			Talb	oot
DIRECTOR	10a. STATE 10b. COUNTY	-	Y, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?
	MARYLAND TALBOT		EASTON				1X YES 2 NO
FUNERAL	10e. STREET AND NUMBER		101. ZIP COL	€ 1601			WHAT COUNTRY?
	416 GLEBE ROAD 11. MARIITAL STATUS 12. WAS DECEDENT 6	VER IN U.S. ARMED	13. WAS DECENDENT		DIOING (Caralle, Var	USA	
	1 Never Merried 2 Merried FORCES? t	YES 2 XNO	If yes, specify Cub	an, Mexicen, Pu		Bla	CE — American Indian, ck, White, etc.
B4	₩Widowed 4 □ Divorced		1 120 222 110	ороспу		Spe	WHITE
ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give kind of w	USUAL OCCUPATION work done during most of work	ing	16b, KIND OF BUS	INESS/INOUSTRY	
	Elementary/Secondary (0-12) College (1-4 or 5+)	iile. Do NOT us	EMAKER			OWN HON	ATP
COMPL	17. FATHER'S NAME (First, Middle, Last)	HON		HER'S NAME /	First, Middle, Maiden		715
- 1	WILLIAM EDWARD COLLIN	S		AMY I		ournerney	
O BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	AOORESS (Street and Number	r or Rural Route	Number, City or Town	n. State, Zip Code)	
	EUDORA C. JACKSON	416	GLEBE ROAL), EAS	STON, M	D 21601	L .
	20e. METHOD OF DISPOSITION X Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		of DISPOSITION (Name of the place) CEMET	ERY 2-		TON, MI	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRI	SS OF FACILIT	v		
	JOHN R. MER	-=-	NEWNAM 1			•	OM MD
	23. PART I. Enter the diseases, or complications that c	aused the death. Do n					Approximate
	shock, or heart fallure. List only one cause IMMEDIATE CAUSE (Final	on each line.	4				Interval Batween Onset and Death
	disease or condition resulting in death)	NUTRIT	120				10 DAK
	DUE TO (O	AS A CONSEQUENCE OF					1
S	DIE TO (O	A AS A CONSEQUENCE OF	AND DIS	> 121)5	2.		6 New 1773
HILICATION	cause. Enter UNDERLYING	THE H CONSEQUENCE OF	<i>y.</i>				i l
Ĭ	that hittated events	AS A CONSEQUENCE OF	ŋ:				
CER	resulting in death) LAST						
AL C	PART II. Other significant conditions contributing to de		n the undarlying cause	givan in Part			b. WERE AUTOPSY FINDINGS
	HYPRETRYSION	1			1 TYES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC	POZETRAKEN	2			1	-X	OF DEATH?
2	DID TOBACCO USE CONTRIBUTE TO CAUS	SE OF DEATH YE	S INO IN	CERTAIN [
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF DEAT	H (Check only one) OTHER:				
PHYSICIAN:		R/Outpatient 3 DOA	4 Nursing Home 5 R				
	1 Natural 5 Pending (Month, Day,		E OF 28c. INJURY AT WORK? M 1 YES 2		I. DEŞCRIBE HOW IN	JURY OCCUREO	
2	2 Accident Investigation 3 Suicide 28a. PLACE OF III	NJURY — A1 home, ferm, s			LOCATION (Street e	nd Number or Burni	Bruta Number
COMPLEIED	4 Homicide 6 Could not be determined building, etc	. (Specify)	,		City or Town, State)	Turnour or ribrar	Troute Transis.
7	29e. CERTIFIER (Check only 1 💢 CERTIFYING PHYSICIAN: To the beat of my	knowledge, death occurre	d at the time, data end place	, end due to th	ne cause(e) end man	ner ee atated.	
∑ []	one) 2 MEOICAL EXAMINER: On the basis of exam	instion end/or investigation	n, in my opinion, death occu	red at the time,	, date end placa, end	due to the ceuse	(e) end manner ee stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LIC	ENSE NUMBER		29d. DATE SIGNE	D (Month, Day, Year)
2	- M Pau	LD.		0002	50 .	Feb.	1 1995
-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE						
	Callum Bain MD. 415 B	East Dover	St. Easto	n Md	21601		
	31. DATE FILED MONTH, Day Year 1995 July alky to	lear harball					1



	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND /		TMENT				MENTAL	HYGIEN	E 1-2	29-9	5 9:48AN	1
	1. DECEOENT'S NAME (FIRST, MIDD CHARLO	fle, Last) Chi	arlotte	RIMMER					2. DATE OF DEATH MONTH			3. TIME OF DEATH	A	
	4. SOCIAL SECURITY NUMBER 169-18-2237	5. SEX 1 ☐ M 2X F	6. AGE (In yrs. les	st birthday) YRS.	MONTHS DAVE		IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) Aug 4 1920		0	e. BIRTHPLACE (State or Foreign Country) Pennsylvania)
TOR	9a. FACILITY NAME (If not inatitution Meridian Heal RESIDENCE OF DECEDE	th Care-Spa	Creek		9b. CITY, An		R LOCATION OF LOCATION	ON OF DE	ATH			nty of the	rundel	
DIRECTOR	10e. STATE 10b.	nne Arundel		10e. CIT	Y, TOWN OF		on Oolis	s					10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	100. STREET AND NUMBER 101 Mansion D							1403			Un		States	
ВУ	11. MARITAL STATUS 1 Never Married 2 Marri XX Widowed 4 Divorced	FORGEON	IT EVER IN U.S. AF	NO	14	yes, spe		n, Maxica	n, Puerto R	? (Specify Yes lican, etc.)	or No-	14. RACI Blac Spec	American Indian, k, Whita, etc.	
COMPLETED	15. DECEDEN (Specify only high Elementary/Secondary (0-12)	IT'S EDUCATION est grade completed) College (1-4 or 5	(G	live kind of a Do NOT ut	usual occ work done du se retired.)	ring mos		eg .	16b.	KIND OF BUS		DUSTRY		
ш	17. FATHER'S NAME (First, Middle, Clarance G.			TOTA	anake		18. MOTH			Hom Hiddle, Maiden Mowre	Sumame)			
TO B	196. INFORMANT'S NAME (Typo/Pr Suzanne Darm								or City or Town	VD 20	735			
	20e. METHOD OF DISPOSITION Burlist 2 Cremation 3 Removal from State Donation 5 Other (Specify)									Maryland				
	Baine	of Phi	llips		14	7 Du	ike d	of G	louce	ster S	St. A	\nnap	olis, MD	e
	23. PART I. Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. PLANTATORY FAULUS BUILT TO DE AS A COMPROVINGE OF THE MARKET OF TH													
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. COPD USAN DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF):										years			
4	Departure de la pressión PERFORMEO? M. C. C. C. C. C. C. C. C. C. C. C. C. C.									WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?				
PHYSICIAN: MEDICA	DID TOBACCO USE C 25. WAS CASE REFERRED TO MED EXAMINER? 1 YES 2 NO		26. PLAC	E OF OEAT	S N TH (Check on OTHER:	ly one)		ERTAIN						_
ву РНУ	27. MANNER OF DEATH 1 Natural 5 Pendic 2 Accident Investi	4 Nursing Home 5 Residence 8 Other (Specify)												
0	4 Homicide detern	nined building,	F INJURY — At he etc. (Specify)						City o	TION (Street a Town, State)			loute Number,	
COMPLET	(Check only one) 2 MEDICAL E) and manner as stated	
296. LICENSE NUMBER 296. DATE AGNI D (Month 297. LICENSE NUMBER 296. DATE AGNI D (Month 297. LICENSE NUMBER 297. DATE AGNI D (Month 297. LICENSE NUMBER 298. DATE AGNI D (Month 298. DATE AGNI D (MONTH 298. DATE AGNI D (MONT								(Month, Day, Year)						

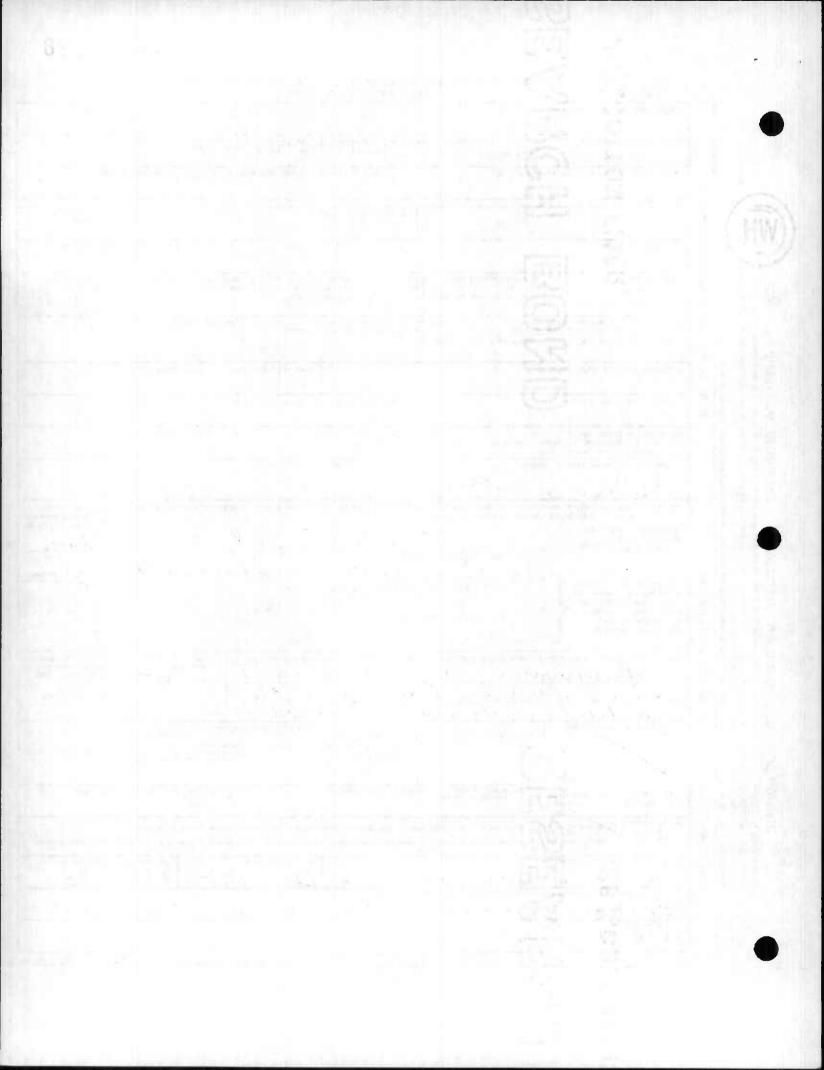


88760, BALTIMORE, MARYLAND 21215-0020	nouted within 24 hours after death. Page 6 may be retained by the hospital or attending	of completely filled in by the funeral director, page 5 should be detached for use as the vurial, cremation, or removal.	tic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trained minimal filled in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

REGISTRAR I. DECEDENT'S NAME (First, Middle, Last)			FICAT	- 01			2 DATE	OF DEATH			3. TIME OF DEATH
Helen Mae Talbe							MONT	H D		YEAR	3. TIME OF DEATH
I SOCIAL SECURITY NUMBER								ary 30	19	95	7:50 P
219-20-4249		AGE (In yrs. last birthd	EACH CELLO	ER 1 YEAR	HOURS	MIN.		OF BIRTH		8. BIRT	HPLACE (State or Foreign try)
	1 🗆 M 2 🏋 F	84 YR						20, 1	910	Mar	ryland
e. FACILITY NAME (If not institution, give a		Center		TY, TOWN O			EATH		9c. COU	NTY OF	HTAS
Westminster Nurs	ing & Conv	alescent	We	estmi	nste	r			Ca	rro]	.1
RESIDENCE OF DECEDENT											
Md. Carro		100	CITY, TOWN								10d. INSIDE CITY LIMITS?
darro	11	I	lew Wi	indso	r						1 TES 2 NO
OO 1 CO TY 1.1	D 1			194	ZIP CODE	E			100		WHAT COUNTRY?
001 Green Valley	Kd.			2	1776				U.	S.A.	
1. MARITAL STATUS	12. WAS DECEDENT E		13	. WAS DEC	ENDENT OF	F HISPAN	NIC ORIGII	17 (Specify Yes	or No-	14. RAC	E — American Indian, ck, White, etc.
Never Married 2 Married Midowed 4 Divorced	IF YES, GIVE WAR				2 NO			HICAN, etc.)		Spec	16
™ widowed 4 □ Divorced	1-										White
15. DECEDENT'S EDU (Specify only highest grade		16a. DECEDEN	of work done			a	168	KIND OF BU	SINESS/INI	DUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	He. Do NO	T use retired.)							
6		Homem	aker					Н	ome		
FATHER'S NAME (First, Middle, Last)					18. MOTH	IER'S NA	ME (First,	Middle, Maiden			
amilton Fritz					Amy	y Yo	ung				
De. INFORMANT'S NAME (Type/Print)		19b; MAIL	ING ADDRE	SS (Street a			_	ber, City or Tow	n, State, Zi	Code)	
arold T. Talbert		25.75						Winds			21776
METHOD OF DISPOSITION		20b. PLACE AND DA				1101	DAT				own, State
Buriel 2 ☐ Cremetion 3 ☐ Ram ☐ Donation 5 ☐ Other (Specify)	noval from State	Kriders					2/3				
I. SIGNATURE OF FUNERAL SERVICE LIK	CENSEE	MITGELS		2. NAME AN	D ADDRES	00 OF EA	1.	wes	CIIITII	ster	, Md.
		111	- 44	D D	. Har	o + o 1	OX				
Valley >	1 1			D . D	· nai	LZI	er				
shock, or heart fallure.	List only one cause	on each line.		New or the mo	Wind	lsor	, Md		ratory sr		Onset and Des
and the second state of the second se	s. Con DUE TO (OF	eused the death. E on each line.	e for: ero	New or the mo	Wind	lsor	, Md	flec or respi	ratory sr		Interval Betwee
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shock, or heart failure. AMEDIATE CAUSE (Finel lesses or condition equentially list conditione, sry, leading to immediate suse. Enter UNDERLYING AUSE (Disease or injury nat initiated events reuting in death) LAST ART II. Other eignificent condition WAS CASE REFERRED TO MEDICAL EXAMINER?	B. DUE TO (OF DUE TO (OF d. D. DUE TO (OF d. D. DUE TO (OF d. D. DUE TO (OF d. D. DUE TO (OF d. D. DUE TO (OF d. D. D. DUE TO (OF d. D. D. D. D. D. D. D. D. D. D. D. D. D.	on each line. As A CONSEQUENCE AS A CONSEQUENCE AS A CONSEQUENCE On the consequence On the consequenc	e of:	New or the modular transfer to the control of the c	Wind de of dyle	Isor Ing, suc Ing, suc Ingliven in	, Md th ss con all all a Part I.	24a. WAS AN PERFOF	AUTOPSY MED?	for	Interval Betwee Onset and Dea Dea Dea Dea Dea Dea Dea Dea Dea Dea
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and the second state of the second se	B. DUE TO (OF DUE TO (on each line. A S A CONSEQUENCE AS A CONSEQUENCE AS A CONSEQUENCE AS A CONSEQUENCE A S A CONSEQUENCE A	OTHER A (MINUTE) M	New er the modern the modern that the modern than the modern than the modern than the modern that the modern than the modern than the modern than the modern that the modern than the modern than the modern than the modern that the modern than the modern than the modern than the modern than the modern than the modern than the modern than the modern t	Wind de of dyle R or R	John In Charles Considerate Co	Part I.	24a. WAS AN PERFOR	AUTOPSY MED?	24l	D. WERE AUTOPSY FINDING AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
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and the condition of th	B. DUE TO (OF DUE TO (eth but not resulting the property of the prop	OTHER OF INJURY Mm, street, fa	New or the modern the modern that the modern t	Wind de of dyle R or G ceuse g Control ACE OF DE B S Rai URY AT P(ES 2 and place, eath occurre	given in Charles and due at the ENSE NUI	Part I. Part I. Color of the care time, data	24a. WAS AN PERFOR	AUTOPSY MED? I NO NJURY OC and Number oner as sta	24l	D. WERE AUTOPSY FINDIN AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO Route Number,



F2.7

FOR

CTATE OF MADVEAUD / DEDUCTION OF HEALTH AND MENTAL INVOICE

	1 - STATE REGISTRAR	TAIL OF MARTIE	CERTIF	ICATE C	F DEA	TH	MENIAL HYGIEN REG. NO.	t			
	1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH MONTH DA	ıv.	YEAR	3. TIME OF DEATH						
			OMAS			Feb. 1, 1	TEAR	1:04 AM M			
	EEO 01 0111		6. AGE (In yrs. lest birthdey) F UNDER 1 YEAR F UNDER 24 HRS. 7. DAYS HOURS MIN. J(M. MONTHE DAYS HOURS MIN. J(M. M. M. M. M. M. M. M. M. M. M. M. M. M							Souri	
TOR	90. FACILITY NAME (If not institution, give street in Frederick Memorial RESIDENCE OF DECEDENT				n on Locat ederic		ATH		nty of d		
DIRECTOR	100. STATE 10b. COUNTY Maryland Frederi	lck		y, town on Lo Freder						10d. INSIDE CITY LIMITS? 1 YES 2XXNO	
FUNERAL	9426 Stoney Hill	Road			10f. ZIP COD 2170				U.S.	VHAT COUNTRY?	
В	1 Never Married 2XX Merried	WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2/L/NO	If yes	DECENDENT (, specify Cube YES 2 NO	OF HISPAN en, Mexicer Specify	IC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	or No —	Black	American Indian, k, White, etc.	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade comp. Elementary/Secondary (0-12) Co		life. Do NOT u.	work done during se retired.)	ATION most of work	ng	16b. KIND OF BUS		DUSTRY		
MP	4		Homei	naker	-		Own H				
BE CO	17. FATHER'S NAME (First, Middle, Last) Unkno	own			16. MOT	HER'S NAI	ME (First, Middle, Meiden Unknown	Sumame)			
T0	Vern Munushian		196. MAILING	ADDRESS (Str.	et and Numbe	or Rumai R Pike	oute Number, City or Tow. Frederic	n, State, Zij k, M	d. 21	1.702	
	20e. METHOD OF DISPOSITION 1										
	21. SIGNATURE OF FUNERAL SERVICE LICENSI	Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan	M00255				sford P.A. ch St., Fr				
	23. PART i. Enter the diseases, or companock, or heart fallure. List iMMEDIATE CAUSE (Final disease or condition resulting in death)	only one chuse on e	each line.				Nas cardiac or reapi	,		Approximata interval Between Onset and Dasth	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease pr injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
	d.										
PHYSICIAN: MEDICAL	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? CONCAL GROUP FROM PROVIOUS 1 YES 2 HOO 1 YES 2 NO										
ä	DID TOBACCO USE CONTRIBL	JTE TO CAUSE C	F DEATH YE	S 🗆 NO	UNC	ERTAIN	10				
C	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	SPITAL:	28. PLACE OF DEA	TH (Check only one) OTHER:							
HYS	1 VES 2 NO 1 C	28e, DATE OF INJURY	patient 3 DOA 28b. TIM		INJURY AT	rsidence	6 Other (Specify) 28d. DESCRIBE HOW II	NJURY OC	CURED		
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	IURY	WORK? YES 2	NO					
COMPLETED	3 Suicide 6 Could not be determined 28s. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 28s. PLACE OF INJURY — At home, ferm, street, fectory, office City or Town, State) 28s. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify)								loute Number,		
PLE	290. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN:	To the best of my know	rledge, death occurr	ed at the time,	late end place	, end due	to the ceuse(e) end man	ner ee sta	ried.		
Š.	One) 2 MEDICAL EXAMINER: On	the beele of examination	n end/or investigation	on, in my opinio	n, death occu	red at the	time, date end place, en	d due to th	he ceuse(e) end menner ee stated.	
BE	290. SIGNATURE AND TITLE OF CERTIFIER	ertet	- m	2	29c. LIC	ENSE NUM	BER C 2			(Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO CO				1/	/53	0/00				
	Dr. Ali James Afro	ookteh MD	300 Wes	t Nint	n Stre	et,	Frederick,	Md.	217	01	
	FEB 0 3 1995	32. REGISTRAR'S SIGN	when Rendal	8							



IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notifiled at once.

DHMH-18 Rev 1/89

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	DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending phys	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-to	with
	NG	fter	eath
	ENDI	R: A	b la
	E	8	s aft
	DR	DIR	OUR

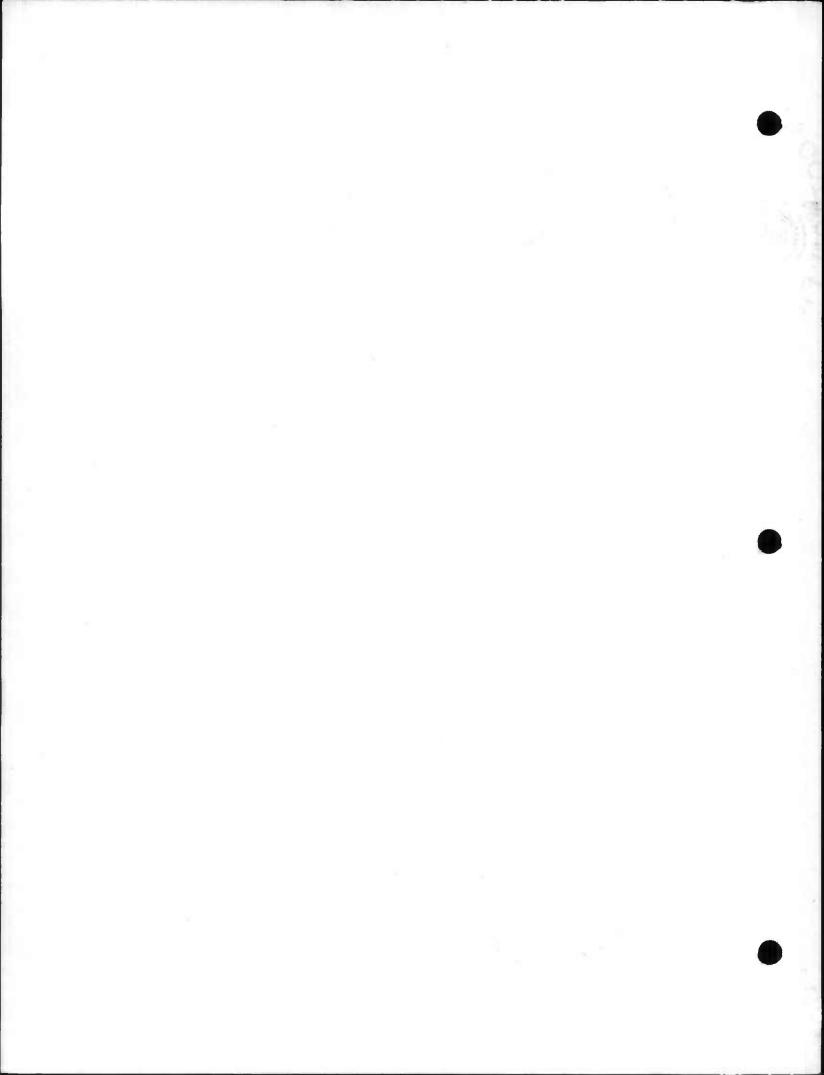
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

be detached for use as the burial-tran TO THE HOSPITAL DR ATTENDING PHYSICIAN: The faw requires that the death certificate be executed within 2-7 hours after death. Page 6 may be retained by the hosp TO THE FINEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

	1 - FOR STATE OF MARYLAND REGISTRAR		NT OF HEALTH AND M	MENTAL HYGIENE REG. NO.	Ē ¹
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	3. TIME OF DEATH
	Gentrude Vinginia Thomas 4. SOCIAL SECURITY NUMBER 5. S.F.X B. AGE (10. NO.			02 01	1995 6:25pm M
	di Andre (in yio,	YRS. WONT	IDER 1 YEAR IF UNDER 24 HRS. HS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	B. BIRTHPLACE (State or Foreign Country)
	2/7-32-74/9 1 M 2 Q F 57 9a. FACILITY NAME (If not institution, give street and number)		CITY, TOWN OR LOCATION OF DE	09/03/193	95. COUNTY OF DEATH
H	202 East "F" Street		Brunswick		Frederick
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY				
DIRECTOR	Manyland Frederick		N OR LOCATION		10d. INSIDE CITY LIMITS?
	100. STREET AND NUMBER	DIL	Inswick		1 ★ YES 2 NO 10g. CITIZEN OF WHAT COUNTRY?
ER/	202 East "F" Street		2/7/6		USA
BY FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S.	ARMED	13. WAS DECENDENT OF NISPAN	IC ORIGIN? (Specify Year	or No- 14. RACE - American Indian
₹	1 Never Married 2 Merried IF YES, GIVE WAR OR DATES 3 Wildowed 4 Divorced	ano .	If yes, specify Cuban, Maxicar 1 YES 2 NO Specify		Black, White, etc. Specify: White
ED E	15. DECEDENT'S EDUCATION 18a	DECEDENT'S USUA	OCCUPATION	16b. KIND OF BUSI	
ETE	(Specify only highest grade completed)	(Give kind of work do the. Do NOT use retire	one during most of working and.)	BLO RR	
COMPLET	12 Ag	ent, Ope	enaton & Clenk	Chessie	System
00	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAM	AE (First, Middle, Maiden S	Surname)
BE	Charles Marshall Cannon 196. INFORMANT'S NAME (Type/Print)			d Josephin	
5	Genald A. Thomas		ess (Street and Number or Pural A ughan's Creek		
	20a. METHOD OF DISPOSITION 20b PLAC	E AND DATE OF DISI			CATION — City or Town, State
	4 Donallon 5 Other (Specify)	rematory or other ple	. (14/95 Bn	unamich Mi)
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FAC	LITY F	1 11
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Banbana A. Williams, Owner		100 Petersvil	le Rd Br	unswick. MD 21716
	23. PART I. Enter the diseases, or complications that caused the shock, or heart fellure. List only one cause on each li	deeth. Do not en	ter the mode of dying, auch	ee cerdiec or respir	ratory arreat, Approximate
	IMMEDIATE CAUSE (Finel		h dheeta	A - A - A	interval Between Onset and Death
	disease or condition resulting in death) a. OUE TO (OR AS A CONS		oncer, ne	lastale	e 6 mez
_	OUE TO (OH AS A COMS	EOUENCE OF):			
CERTIFICATION	Sequentielly list conditions, if any, leeding to immediate DUE TO (OR AS A CONS	EQUENCE OF):			
S	cause, Enter UNDERLYING CAUSE (Disease or injury				
Ë	that initiated eventa DUE TO (OR AS A CONS resulting in death) LAST	EOUENCE OF);			
	d				
SAL SAL	PART II. Other eignificant conditione contributing to death but no	reaulting in the	underlying cause given in i	Part I. 24s. WAS AN A PERFORE	MED? AVAILABLE PRIOR TO
MEDIC				1 YES 2	OF DEATH?
Σ					1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH (Che	ck only one)	
Sic	EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Oulpatiant	3 DOA 4	IER:	B Other (Specify)	
H	27. MANNER OF GEATN 1X Netural 5 Pending 28a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	28c. INJURY AT WORK?	26d. DESCRIBE HOW IN	JURY OCCURED
ВУ	2 Accident Investigation	N	T TES 2 NO		
ED	3 Suicide 6 Could not be datermined 28a. PLACE OF INJURY — At building, etc. (Specify)	home, ferm, street,	fectory, office	28f. LOCATION (Street ar City or Town, State)	nd Number or Rural Route Number,
	29s. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge,	dooth assured at 11			
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/o				
	29b. SIGNATURE AND TITLE OF CERTIFIER	10.10	29c. LICENSE NUM		29d. DATE SIGNED (Month, Day, Year)
O BE	U Myain	TU	1016		1 2/2/95
10	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (17			MN 7	171/
	31. DATE FILED (Morith, Day, Year) 32. REDISTRAR'S SIGNATURE		MNSWICK !	L CO	116
	FEB 0 3 1995 Julia dander	Rendelle			
	- 4 1000 //	- 44-9			



FOR

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

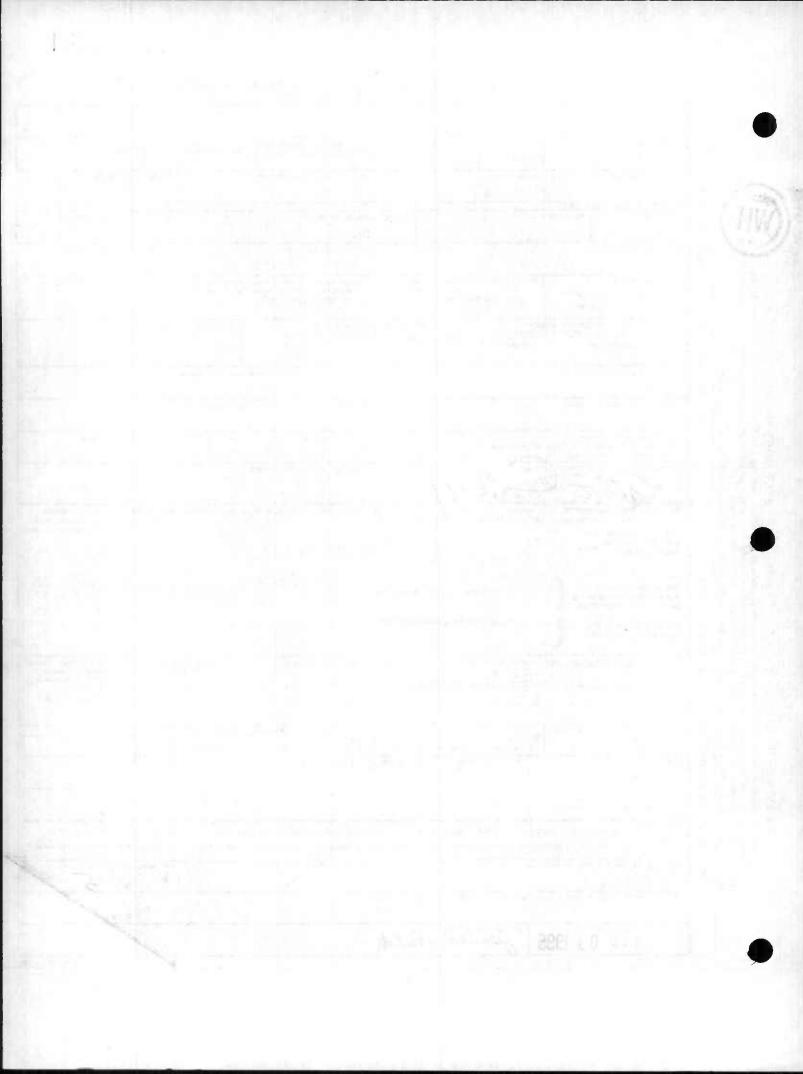
1 - STATE REGISTRAR		JIMIE OI W	CE	RTIF			DEATH		MENIA	REG. NO						
1. DECEDENT'S NAME (First, A	Middle, Last)									OF DEATN			3. TIME OF DEATH			
FREDERIC	K GEOR	GE TR	AUTMAN						MONTH	-31-95	AY YEAR		1:05			
4. SOCIAL SECURITY NUMBE	URITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH							OF BIRTH	,	8. BIRTI	PLACE (State or Foreign					
216-01-30	(Month Day Year								26/19	13	Count	vland				
9a. FACILITY NAME (If not inst	2	,	- 01		9b. CIT	TY. TOWN O	OR LOCATION	OF DE		20/17		COUNTY OF DEATN				
Citizens Nu	rsing l				-363	rede						eder				
	10b. COUNTY			10c, CIT	Y, TOWN	OR LOCAT	TION	-				-	10d. INSIDE CITY			
Maryland	Freder	ick		Fı	ede	rick							LIMITS?			
100. STREET AND NUMBER						101	, ZIP CODE				10g. CI	TIZEN OF	WHAT COUNTRY?			
803 Gabriel	L Court	Apt. #	302				21702					U.S.A	A.			
11. MARITAL STATUS 1 Never Married 2 N 3 Widowed 4 Divorce	farried	FORCES? 13		MED IO	13	If yes, sp	ENDENT OF ecity Cuban, 2 X NO	Mexica	n, Puerto f		a or No	14. RAC Blac Spec	E — American Indian, k, White, etc. #y: White			
15. DECEI (Specify pnly)	DENT'S EDUCATE	ON poleted)	16a. DE	CEDENT'S	USUAL	OCCUPATIO	ON st of working		16b.	KIND OF BU	SINESS/II	NDUSTRY				
Elementary/Secondary (0-1		ollege (1-4 or 5 +	Ma	Do NOT u	se retired	.)	o. or working						The York Walls			
10 years			Bı	is Dr	ive	r				None						
17. FATHER'S NAME (First, Mid	idle, Lest)						18. MOTHE	R'S NA	ME (First, A	Hiddle, Maiden	Sumame)					
Henry Joseph	Trauti	nan					Caro	lir	ne Bi	ggen			braiks in the			
19a. INFORMANT'S NAME (Typ			190	. MAILING	ADDRE	SS (Street a	and Number or				vn, State, 2	Zip Code)				
Helen B. Tr	autman			303 (Gabr	iel (Court	Apt	t. #3	302 Fr	eder	ick,	MD 21702			
20e. METNOD OF DISPOSITION 1 Burlal 2 Cremation 4 Donation 5 Other (S	3 🗆 Removal	from State	20b. PLACE / cometery, cre Smit)	MD DATE	OF DISPO	OSITION (Na	arme of		DATI			- Cily or To				
21. SIGNATURE OF EUNERAL		133	SILLU	ISDUI			ND ADDRESS	OF FA	1/3	011 9111	ııns	burg	Maryland			
* Polon	40	Sil	elt.	,	R	OBER	r E. D	AII	LEY &				HOMES, P.A.			
23. PART I. Enter the dis	entes, or com	plications that	capsed the de	ath. Do									MD 21701			
IMMEDIATE CAUSE (Fine disease or condition resulting in death)	art fallure. List	only offe cau	se on fact line LESECO	OUENCE O	200	£1	acte	the					Interval Batween Onset and Death			
Sequentielly list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or injury that initiated events resulting in death) LAST	late IG y	DUE TO	OR AS A COMME	HENCE O	lou	wo	űa.						cyous			
PART II. Other aignifican	-0.	0	death but not r		in the	underlyin	g ceuse glv	ren in	Part i.	24s. WAS AF PERFO 1 YES	RMED?	241	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
25. WAS CASE REFERRED TO	MEDICAL	-		_		28. PI	LACE OF DEA	TH (Ch	eck only on	ne)						
EXAMINER?	H	OSPITAL:	EB/Outestine 5	□ pos	ОТН	ER:										
27. MANNER OF DEATH		28s. DATE OF	ER/Outpatient 3	28b. TIN		7	IURY AT	pence		r (Specify)	IN HIEW O	COURED				
1 Netural 5 P		(Month, De			JURY	WC.	PRK?	NO	200. DES	CHIBE NOW	INJUNT	CCORED				
2 Accident Investigation 3 Suicide 6 Could not be determined 28s. PLACE OF INJURY — Al home, farm, street, factory, office building, atc. (Specify) 28s. PLACE OF INJURY — Al home, farm, street, factory, office City or Nown, State)								Floute Number,								
onel			my knowledge, de amination and/or										a) and manner as stated.			
29b. SIGNATURE AND TITLE	OF CERTIFIER	7					29c. LICEN	SE NUI	MBER		29d. D/	ATE/SIGNE	(Month, Day, Year)			
Jornard 1	Dilt	conco	0				134	f0	9		•	1/31	95			
30. NAME AND ADDRESS OF	PERSON WHO C	OMPLETED CAUS	E OF DEATH (ITE	М 27) (Туре	, Print)							771				
31. DATE FILED (Month, Day, N		32. REGISTRA	R'S SIGNATURE	Carlel	Si.			Ť				т				

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Tours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any finjury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-18 Rev 1/89



BALTIMORE, MARYLAND 21215-0020	L. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physicial	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-to hours after death with the State Deut, of Health and Mental Hydiere prior to burial, cremarion, or remnal
	Par 24	mation
DIVISION OF VITAL RECORDS, P.O. BOX 68760	ted with	comple lal. crei
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R ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	RECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tran	r dea	on 98 to mondand on them 93 above and indicate our added the months around the months of months and the months are
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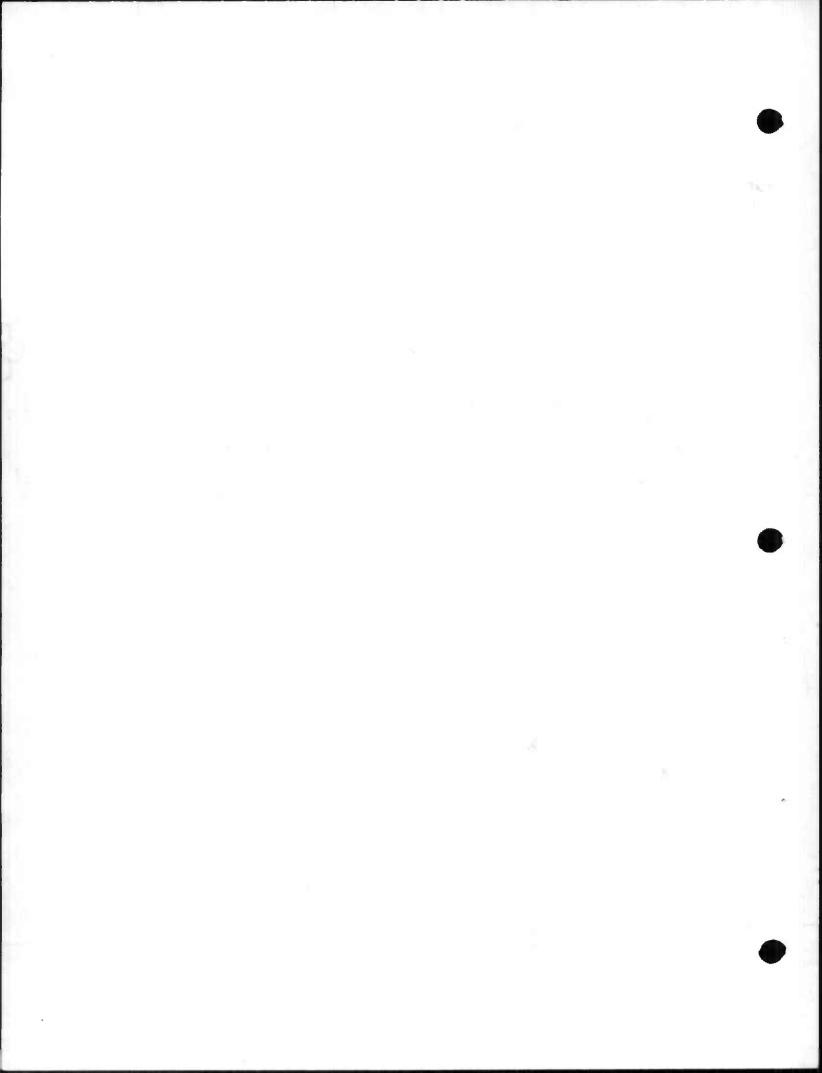
										90) 11	1042
		1 - FOR STATE REGISTRAR	STATE OF MARY					EALTH AND	MENTAL HYGIE			
		1. DECEDENT'S NAME (First, Middle, Last)	1						2. DATE OF DEATH		3.	TIME OF DEATH
		Forrest	h.	Ta	vlo	TC			February	DAY /	YEAR 995	0305 M
6		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last I	birthday)	IF UNDER	YEAR	IF UNDER 24 HRS.	7 DATE OF BIRTH			ACE (State or Foreign
		578-05-7891	1 ⊠ M 2 □ F	79	YRS.	MONTHS	DAYS	HOURS MIN.	May 7, I	915	Cquntry)	Of Col.
1	23	Se. FACILITY NAME (If not institution, give :	street end number)			9b. CITY	TOWN O	R LOCATION OF E			NTY OF DEAT	
1	5								ZAITI	90.000	NIT OF DEAL	п
THAT	Nĕa	Washington Adv	ventist Ho	spita	a L	T'a.	KOM	a Park		Mor	ntgom	ery
AFIN	肥	10a. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN OF	LOCAT	ION			10-	d. INSIDE CITY
(S. P.)	o.				Wa	ashi	ngt	on			1 (LIMITS7 YES 2 NO
	A	10e. STREET AND NUMBER					_	ZIP CODE		10g. CIT	IZEN OF WHA	
n. Insit	FUNERAL	2719 Georg	ria Ave. N	W Z	h+t	#102		20001		11	S.A.	
physician. burial-transit	5	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARM	ED	13. W	AS DEC	ENDENT OF HISPA	INIC ORIGIN? (Specify Y			Americen Indian, hite, etc.
phy pur	BY F	1 Never Married 2 Merried	FORCES7 1 X YES)	16	yes, spe	city Cuben, Mexic 2 X NO Spec	an, Puerto Rican, atc.)			
attending physician se as the burial-tra		3 Widowed 4 Divorced	<u> </u>			<u> </u>					BI'a	ck
or atte	ED	15. DECEDENT'S EDU (Spectly only highest grade		(Give	kind of v	USUAL OCH		N st of working	16b, KIND OF B	JSINESS/INC	DUSTRY	
ital or	۳	Elementery/Secondary (0-12)	College (1-4 or 5+)			e retired.)				_		
the hospital detached to once.	COMPLET	Ilth_Grade		GI	cour	nds-I	kee	per	Howa	rd Ur	niver	sity Hosp
	8	17. FATHER'S NAME (First, Middle, Last)	_					16. MOTHER'S N	AME (First, Middle, Melde	n Sumeme)		
od by	BE	John L. Tay	lor						ttie For			
should 5 should notified	2	19e. INFORMANT'S NAME (Type/Print)	reat Neice	≘) 196.	MAILING	ADDRESS	(Street er	nd Number or Rural	Route Number, City or To	wn, State, Zip	Code)	20783
			iriton	1	.836	Met	zei	rott R	d, Apt#14	105,	Adeli	onia, Md
e 6 may ector. pa must b		20a. METHOD OF DISPOSITION 1 Burlel 2 □ Cremation 3 □ Rem	oval from State ce	b. PLACE AN	DOATE C	her placel	TION (Nat	me of	DATE 20c. L	DCATION —	City or Town,	Siate
Page 6 al directo ner mu	- 4	4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIG	F	Tarmo	ny				c 2/11 La	ındov	er, 1	Md
death. Page 6 may be a funeral director, page 1.	. 1	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	/				D ADDRESS OF F	neral Hon	ne P	Δ 20	0850
0 = 0		(SUNSE 1	· Duewe	Ser	_				nington S			
E 3 X B		23. PART I. Enter the diseases, or	complications that ceuse	d the deat	h. Do n	ot enter t	ha mod	de of dying, su	ch es cerdiac or rea	piratory arr	reat,	Approximata
no or		IMMEDIATE CAUSE (Final	List only one cause on	each line.								Onset and Death
		disease or condition resulting in death)	· Kepic	Jon	2	e 1/	1					
	i	rooming in adulti	DUE TO (OR AS DU	A CONSECTO	ENCE OF	7:	LVI					
executed n and con to burial,	z		· Consilio	ne	1		2	12-00-				
ertificate be executaing physician and cognitions prior to buriand the traumatic	RTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEOU	ENCE OF	7:						
ysicial prior r trau	2	Cause. Enter UNDERLYING CAUSE (Disease or Injury	c 5295.	3								
nding physi Hygiene pri or other to	E	that initiated eventa resulting in death) LAST	DUE TO (OR AS									
endi Hy	W	resulting in death) LAST	d. 850572	10	C		-					
	2	PART II. Other algnificant condition	is contributing to death !	but not res	ultino i	n the und	erivina	Ceuse Given In	Part I. 24a, WAS A	MAIITOBEV	245 WE	RE AUTOPSY FINDINGS
that the done of the sand Men and Men and Men	MEDICAL		_				orrying	Count given	PERFO	RMED?	AWA	MILABLE PRIOR TO MPLETION OF CAUSE
S lea									1 YES	2 940		DEATH7
w requires been sign pt. of Healt shows		DID TOBACCO USE CONT	DIDLITE TO CALISE (DE DEATI	1 VE	c \square N		LINICEDTAL			1 [YES 2 NO
has be Dept.	A	25. WAS CASE REFERRED TO MEDICAL	KIBUTE TO CAUSE C	26. PLACE				UNCERTAI	NE			
V: The icate h State I	S	EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER:		0.00				
SICIAN: The law certificate has the the State Dept d. or Item 23	PHYSICIAN:	27. MANNER OF DEATH	1 inpatient 2 ER/Out		28b. TIME	T -	es Home		8 Other (Specify)			
NG PHYS fler this c eath with marked,	- 51	1 Netural 6 Pending	(Month, Day, Year)		INJU		WOF		28d. DEŞCRIBE HOW	INJURY OCC	JURED	
After death	BY	2 Accident Investigation 3 Suicide 6 Could get be	280. PLACE OF INJURY	Y — At home	form e	treet factor			and Location (Comme			. (91)
TTEND TTOR: / after d after d 28 is		4 Homicide 6 Could not be	building, atc. (Spe	ecity)	, 101111, 0	tieet, rector	y, ornew		28f. LOCATION (Street City or Town, State	end Number	or Rural Houte	Number,
OR ATTENDING PHYSICIAN: The law DIRECTOR: After this certificate has b hours after death with the State Dept. Item 28 is marked, or Item 23	COMPLET	29a, CERTIFIER										
対域な ==	d d	(Check only	CIAN: To the best of my know									
HOSPITAL FUNERAL WITHIN 72	8	2 MEDICAL EXAMINE	R: On the basis of examination	on end/or Inv	estigation	n, in my opi	nion, de	eth occured at the	time, date and place, e	nd due to the	e cause(e) end	s manner ee stated.
TO THE HOSPI TO THE FUNEF be filed within	BE	296. SIGNATURE AND TITLE OF CERTIFIER	1					29c. LICENSE NU	MBER	29d. DATE	E SIGNED (Moi	nth, Day, Year)
5 5 8 M	0	M m	2)					0 -	46093	> 2	-/1/95	-
	L-0 12	30 NAME AND ADDRESS OF DEDSON WA	O'COMBI ETER OLUME OF THE		-							

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)
FEB 03 1995

3) Aghn 7-30 31. JEGISTRAN'S SIGNATURE

DHMH-16 Rev 1/89



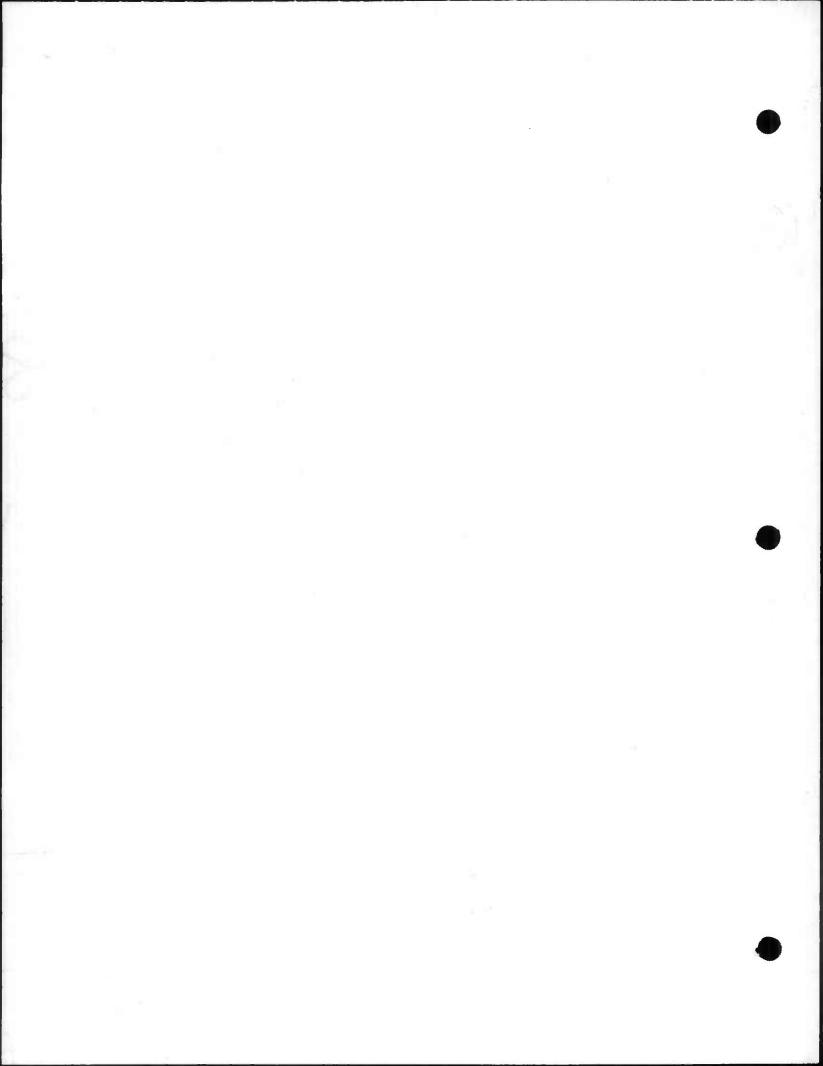
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a flor float float. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trape filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

A 15.00

	1 - FOR STATE REGISTRAR	ATE OF MARYLAN	ID / DEPAR	TMENT OF H	EALTH AND I	MENTAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			3. TIME OF DEATH
	ALBERT L	. //	HOM	AS		FEBRUCIY (0/	YEAR 1995	10:15 AM
	4. SOCIAL SECURITY NUMBER S. SE		rs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BIRTH		B. BIRTHP Country	LACE (State or Foreign
		M 2 □ F 62	YRS.	MONTHS DAYS	HOURS MIN.	NOV 20, 1	932	Mai	ryland
ا ي	9a. FACILITY NAME (If not institution, give street and				R LOCATION OF DE	ATH	9c. COU	NTY OF DE	ATH
ᅙ	Shady Grove Adver	itist Hos	pital	Rock	ville		Mon	tgor	nery
DIRECTOR	10e. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCAT	ION				10d. INSIDE CITY
	Maryland Montgon	nery	S	andy S	pring				LIMITS?
FUNERAL	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITI	ZEN OF WI	HAT COUNTRY?
	18567 Brooke F				20860			J.S.A	Α
	1X Never Married 2 Married FO	AS DECEDENT EVER IN U.S DRCES? 1 YES 2	≥ ZNO	If yes, sp	city Cuban, Maxica	IIC ORIGIN? (Specify Yea n, Puerto Rican, atc.)	or No-	14. RACE Black,	— American Indian, White, atc.
B	3 Wildowed 4 Divorced	YES, OIVE WAR OR DATES	S	1 🗆 YES	2 X NO Specify	r	[Bla	ck
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade complete	ted) 16	a. DECEDENT'S I	USUAL OCCUPATION	N et of working	16b. KIND OF BUS	INESS/IND		
9	Elementary/Secondary (0-12) Colle	ge (1-4 or 5+)	life. Do NOT use	retired.)					
₽ B	9th Grade 17. FATHER'S NAME (First, Middle, Last)		Cement	Finis		Cons		tior	1
		nomas				ME (First, Middle, Maiden			
BE		cother)	19b. MAILINO	ADDRESS (Street a		tte Wall		Code	
2	(DI	other)	185	67 Bro	oke Rd,	Sandy S	orin	a. M	14 20860
	20a. METHOD OF DISPOSITION 1X Buriel 2 Cremetion 3 Removal fro	20b. PL.	ACE AND DATED	F DISPOSITION /No	ma of	DATE 200 LO	_	City or Tow	
	4 Donation 8 Other (Specify)	ASI	n. Gremetory or oth	rial Co	emetery	2/7 Sai	ndy	Spri	ng, Md
1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	1		Show	ADDRESS OF FAC	eral Home	o D	Δ 2	0.085.0
;	COLNGE RI	mond	u-	246	V. Wash	ington S	t Ro	ckvi	lle. Md
	23. PART I. Enter the diseasea, or compile ahock, or heart failure. List on	cations that caused th	e death. Do n	ot enter the mo	de of dying, suci	n aa cardiec or reapi	ratory arr	eat,	Approximate
	IMMEDIATE CAUSE (Finel								Interval Between Onset and Death
	disease or condition	uren							2 weeks
		Widne	0						5415
RTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CO							1 7/ 3
3	cause. Enter UNDERLYING CAUSE (Disease or injury								
	that initiated events resulting in death) LAST	DUE TO (OR AS A CO	NSEQUENCE OF):					
SER	d								
A	PART II. Other significent conditions contri	ribyting to deeth but r	not resulting is	the underlying	ceuse given in	Part I. 24a. WAS AN			WERE AUTOPSY FINDINGS
EDIC	dement	F12				1 - YES 2			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Σ∥							7		YES 2 NO
HYSICIAN:	DID TOBACCO USE CONTRIBUT				UNCERTAIN	1 🗆 📗			
3		PITAL:		OTHER:					
Ĕ I		8a. DATE OF INJURY	nt 3 🗆 DOA		8 Residence	8 Other (Specify) 28d. DESCRIBE HOW II	LILIBY OCC	THRED	
2	1 Natural 5 Pending	(Month, Day, Year)	INJU	IRY WO	ES 2 NO	202. DEQUINDE NOW II	BONT OCC	ONED	
- 10	3 Suicide & Could not be	8a. PLACE OF INJURY —//	At homa, farm, at	reat, factory, office		281. LOCATION (Street a	nd Number	or Rural Ro	ute Number,
	4 Homicide determined					City or Town, State)			
COMPLEIED	29a, CERTIFIER (Check only one)								
5	one) 2 MEDICAL ENAMINER: On th	e basis of assenination and	d/or Investigation	, in my opinion, d	ath occured at the	time, data and place, and	due to the	e cause(a)	and manner as stated.
N I	296. SIGNATURE AND TITLE OF DESTIFIER				29c. LICENSE NUM	BER	29d. DATE	E SIGNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PURSON WITH COMP		WT The act		D351	103	P 3	coma	171,1595
	122-60			Montro	ce 0 1	? Rocky	1/		2 (=
	31. DATE FILED (Month, Day, Year) 32	2. REGISTRAR'S SIGNATUI	RE		, - rel	, rocky	1/2	no.	20852
	FEB 03 1995 Juli	Davidson Rando	M						



DIVISION OF VITAL RECORDS, P.O. BOX 68760

	FOR 1 - STATE REGISTRAR	STATE OF N	TARYLAND	/ DEPAR	RTMENT	T OF H	IEALTH DEAT	AND	MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE	OF DEATN			3. TIME OF DEATH
	James H. V	alcour							Tanı	nary 3	AY T TO	YEAR	12:03 P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	lest birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS		OF BIRTH	1, 19		PLACE (State or Foreign
	577-02-9833	1 [X] M 2 □ F		O YRS.	MONTHS	DAYS	HOURS	MIN.	(Mont	h, Day, Year)		Country	r)
	9e. FACILITY NAME (If not institution, give s			- 110	A1 A1T					. 31,			
œ							OR LOCATION		EATH		9c. COU	NTY OF D	EATN
5	Frederick Memoria	1 Hospit	al		F	'rede	erick				Fr	eder	ick
Ö	10a. STATE 10b. COUNTY	,		10c. CIT	Y, TOWN (OR LOCAT	ION						10d, INSIDE CITY
DIRECTOR	Maryland Fre	derick			Fred	eric	k						LIMITS?
4	10e. STREET AND NUMBER				-	101	. ZIP CODI	E			10a CITI	ZEN OF W	HAT COUNTRY?
FUNERAL	121 Willowdale	Drive #]	.1			1.0	2170						-1000
Ž.	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S.	ARMED	12	WAS DEC	ENDENT C	NE MISBAI	MIC OBION	17 (Specify Yes			States
	1 🔀 Never Married 2 🗌 Married	FORCES? 1 IF YES, GIVE W	YES 2X	Mo		If yes, sp	ecify Cuba	n, Mexica	n, Puarto	Ricen, etc.)	or No —		— American Indian, White, etc.
ВУ	3 Widowed 4 Divorced	IF TES, GIVE W	AR OR DATES			1 YES	2 📉 NO	Specif	fy:			Specif	White
G	15. DECEDENT'S EDUC	CATION	16a. I	DECEDENT'S	USUAL O	CCUPATIO	ON		16b	. KIND OF BU	SINESS/IND	DUSTRY	
ET	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +		(Give kind of the Do NOT us	work done se retired.)	during mo	st of working	ng					-
P		1		Stude	nt				E	ducati	on		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTI	NER'S NA	ME (First, i	Middle, Maiden	Surname)		
В	Francis L. Valc	our					M	aure	en A	. Cole	man		
BE (19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	S (Street a		_		ber, City or Tow		Code)	
5	Francis L. Valco	ur								a, Mar			0814
	20e. METNOD OF DISPOSITION			EANDDATE					DAT		CATION —		
	1 Surial 2 Cremetton 3 Remo	ovat from State	Gate	of H	ther place)	n Ce	mete	rv 2	1				, Maryland
	21. SIGNATURE OF FUNERAL SERVICE OF	EMBEE /	Juce	01 11									
	DM1. 1 11	5 2/6:	,	M0084	6 Be	pert thes	da-C	Pump	nrey Cha	Funer	al H	ome/	Visconsin -3501
_	or freehan a	CA DAGES	UN .		Āv	enue	, Be	thes	da,	Maryla	nd 2	0814-	-3501
	21 PART L Enter the diseases, or c shock, or heert fellure.	complications tool	csused the ese on each in	deeth. Do i ne.	not enter	the mo	de of dyl	ing, auc	h es cere	tiec or reepi	ratory sn	rest,	Approximata interval Between
	IMMEDIATE CAUSE (Finel												Onset and Death
	disease or condition resulting in death)	Sudde	n Card	iac D	eath								
	DUE TO (OR AS A CONSEQUENCE OF):												
Z	Sequentially list conditions, Due to (or as a consequence of): Ventricular Arrythmia												
Ĕ	if sny, leading to immediate cause. Enter UNDERLYING						-1.						
5	CAUSE (Disesse or injury		ex Con			eart	DIS	ease					
Ë	that initiated events resulting in death) LAST	502 10	OH AS A CONS	EOUENCE O	r):								İ
CERTIFICATION		1									-		
_	PART II. Other significant conditions	s contributing to	deeth but not	resulting	In the un	derlying	ceuse g	lven In	Part I.	24e. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
5										PERFOR			AVAILABLE PRIOR TO COMPLETION DF CAUSE
Ä										1 TES 2	X. No		OF DEATH? 1 ☐ YES 2 ☑ NO
PHYSICIAN: MEDICA	DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF DE	ATH YE	S 🗆 I	NO E	UNC	ERTAI	νП			ı	
X	25. WAS CASE REFERRED TO MEDICAL			ACE OF DEAT									
SIC	EXAMINER? 1 🔀 YES 2 🗌 NO	HOSPITAL:	ER/Outpatient	3 DOA	OTHER		e 5 ∏ Re	sidence	6 Othe	r (Specify)			
ΞI	27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIM	E OF	28c. INJ	URY AT			CRIBE HOW I	NJURY OC	CURED	
	1 Natural 5 Pending	(Month, Da	ly, 1981)	INJ	URY M		RK? 'ES 2 [NO					
BY	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OI	INJURY — At I	home, farm, i	street, fact	ory, office			28f. LOC	ATION (Street 1	and Number	or Rural R	oute Number,
COMPLETED	4 Nomicide determined	bunding,	etc. (Specify)						City	or Town, State)			
٦	29a. CERTIFTER (Check only 1 X CERTIFTING PHYSIC	CIAN: To the heat of	my knowledge	death occum	and and the analysis	lma stata	and stees	114 4	A		-2 -02.1	u,	
M	(Check only one) 2 MEDICAL EXAMINE												
	290. SIGNATURE AND, TITLE OF CENTIFIER				.,,					arta piaca, art			
H	100000		1			Į	29c. LICE						(Month, Day, Year)
~ 1	C DVI OF	COMPLETED ONLO	E OF DEATH "Y	EM 270 /*	Drip#1		D1	3992			Fe	brua	ry 1, 1995
유	30. NAME AND ADDRESS OF PERSON WILL			No. 10 (1/10)	rmn)								
ř	P. Jacob Varohese					7) ====	2170	NT 1.1	7.7	ach i	L a	DC	20027 2226
ĭ	P. Jacob Varghese	M.D. 21	50 Pen	nsylv		Ave	nue,	N.W	., W	ashing	ton,	DC	20037-2396
T	and the same of th	M.D. 21		nsylv		Ave	nue,	N.W	., W	ashing	ton,	DC	20037-2396

	1 - STATE REGISTRAR	STATE OF I		ERTIF					MENIAL	HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE O	F DEATH	NA.	YEAR	3. TIME OF DEAT	н
	BETTIE 4. SOCIAL SECURITY NUMBER	Μ.	WETZEL							ary 22		995	17:11	Рм
	243-18-2685	5. SEX	6. AGE (In yrs. las	YRS.	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE O (Month,	4, 19	22	8. BIRTH	th Carol	reign
	9e. FACILITY NAME (If not institution, give a		12	1110.	9b. CITY	r, TOWN O	B LOCATI			4, 15	_	INTY OF D		ша
DIRECTOR	KENT & QUEEN A	NNE'S HOS	SPITAL					ERTO			3 C. COO	KENT		
3EC	10e. STATE 10b. COUNTY	1		10c. CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY	
۵		ent				Cl	hest	erto	wn				LIMITS?	NO
E .	10e. STREET AND NUMBER	10e. STREET AND NUMBER					ZIP COD						VHAT COUNTRY?	
PUNERAL	10796 Mallard Poi	Mallard Point Road						620					tates	
BY P	1 Never Merried 2 Merried 3 Widowed 4 Olvorced	12. WAS OECEDEN FORCES? 1 IF YES, GIVE W	YES 2	NO		WAS OECI If yes, spe 1 YES	cify Cuba	OF HISPAN In, Mexical Specify	n, Puarto Ri	(Specify Yes can, etc.)	or No-	14. RACE Black Speck	E — Americen India k, White, etc. //y:	n,
0 8	15. DECEDENT'S EQU	CATION	16a DE	CEDENTIO					Lance				ite	
ETE	(Specify only highest grade		(G	CEDENT'S live kind of a Do NOT us	work done	during mos	N it of workir	ng	16b. I	KINO OF BUS	SINESS/IN	OUSTRY		
COMPLETED	12	3		elem	arke	ting			R	etai1	Sal	es		
	17. FATHER'S NAME (First, Middle, Last) Henry Moore									ddle, Maiden				
BE	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	AOORES	S (Street ar		-		r, City or Town		o Code)		-
٩	Robert D. Wetzel		1	L0796	Malla	ind Po	int R	oad,	Cheste	rtown,	Mary	land	21620	
	20a. METHOD OF DISPOSITION 1	oval from Stata	20b. PLACE of cemetery, cre	matory or o	ther place)			. 26	0ATE			City or To		
	21. SIGNATURE OF FUNERAL SERVICE	Engle/	Capito	a die	22.	NAME AN	O AOORE	SS OF FAC	עפפו מונודץ	unera	t, 1e.	Lawalle		
	William L.	King Jr.	-	n									land 21.620	- 1
┪	23. PART i. Enter the diseases, or o	omplications tha	t caused the de	ath. Do r									Approxima	
	shock, or heart fallure. iMMEDIATE CAUSE (Final	924					4						Onset and	
	disease or condition resulting in death)	- Lefs	OR AS A CONSE	to	Bil	refu.	10	Pull	uno.	uia				
		FLG.	(OR AS A CONSEC	OUENCE O	F):									
0	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSE	DUENCE O	ecre	un	~							
RTIFICATION	cause. Enter UNDERLYING	a												
	that initiated events	OUE TO	(OR AS A CONSEC	DUENCE OF	F):									
CER	Todating in death, End	1												
CAL	PART ii. Other significant condition	s contributing to	death but not r	esuiting	in the ur	derlying	cause (given in I	Part I.	24a. WAS AN		24b.	WERE AUTOPSY FIR	
	CHT-, 1+39								_	1 TES 2		-	COMPLETION OF C	
MED									_				1 - YES 2 - N	0
SICIAN:	DID TOBACCO USE CONTI	RIBUTE TO CA		TH YE			UNC	ERTAIN	1 🗆					
2	EXAMINER?	HOSPITAL:			OTHER	₹:	□ n	ald-no-	e 🗆 Ottor	(0/4-)				-
PHY	27. MANNER OF DEATH	28e. DATE OF	INJURY	28b. TIM	E OF	28c. INJL	RY AT	eldence	6 Other	RIBE HOW IN	JURY OC	CUREO		-
BY	1 Natural 5 Pending 2 Accident Investigation	(Month, D.		INJ	URY M	1 Y		NO						
	3 Suicide 8 Could not be 4 Homicide detarmined	28e. PLACE O building,	F INJURY — At ho etc. (Specify)	me, farm, a	rtraet, fect	ory, office			28f. LOCAT	TON (Street e Town, State)	nd Number	r or Rural R	loute Number,	
<u> </u>	20. CERTIFIER													
COMPLEIED	(Check only one) 1 CERTIFYING PHYSIC MEDICAL EXAMINE												end menner ee st	nted.
- 11	A96. SIGNATURE AND TITLE OF CERTIFIE							NSE NUM					(Month, Day, Ybar)	
20 20	4 C. ausla	> MI	ð.				05	388	7-9		•	1/2	3/95	
-	30. NAME AND ADDRESS OF PERSON WHO	1 1.0	SE OF OEATH (ITE	M 27) (Type,	-		21	0	210	. 2 ^				
	31. OATE FILED (Month, Day, Year)	32. REGISTRA	T'S SIGNATURE	yen		ery	, and	-=(c (4	20			· · · · · · · · · · · · · · · · · · ·	
	JAN 30 '95	J di	ilia Davids	on-Pa	ndell									
				_			_	_						

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Pages 1, 2, 3 should

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the before within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-

	1 - STATE REGISTRAR	STATE OF MARYLAND		IENT OF HEALTH AND ATE OF DEATH	MENTAL HYGII		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH	DAY Y	a. TIME OF DEATH
	Lena	<u>Harrie</u>	tt	Williams	January	21 199	
	- 1 // Dla	5. SEX 6. AGE (In yrs.		UNDER 1 YEAR IF UNDER 24 HRS. WITHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	1891	BIRTHPLACE (State or Foreign Country)
OR	98. FACILITY NAME (If not institution, give stre The Kent and Queen			Chestertow	DEATH	9c. COUNTY Ker	
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	4	40- 0174 7	WELOD LOCATION			
- DIRECTOR	md. Ko	*#	0 1		WH		10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	7516 QUAL	ER ROAZ	1	2/6	20	10g. CITIZEN	OF WHAT COUNTRY?
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	ABMED XNO	13. WAS DECENDENT OF HISP If yes, specify Cuben, Maxi 1 TYES 2 NO Spe	can, Puarto Rican, etc.)	Yes or No — 14.	RACE — American Indian, Black, White, atc.
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12)	College (1-4 or 5 +)	DECEOENT'S USU (Give kind of work life. Do NOT use re	done during most of working		Om E	,
BE COI	17. FATHER'S NAME (First, Middle, Lest)	OWSER		18. MOTHER'S I	NAME (First, Middle, Maid RRIE	en Surname)	
10	GREGOR	THOMAS		CATUERT		own, State, Zip Co	
	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remov Donation 5 Other (Specify)	al from State 20b. PLAC cemetary,	CEAND DATE OF D	SPOSITION (Name of	DATE 20c.	LOCATION - City	FROWN, State
	21. SIGNATURE OF FUNERAL SERVICE LICE	SEE SOL		22. NAME AND ADDRESS OF 207CALL	IERT ST	REE ?	2/620
	23. PART I. Enter the diseases, or co	mplications that caused the st only one cause on each i	death. Do not	enter the mode of dying, su	ich as cardiac or re	piratory arreat	, Approximata
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	Artera	oscle	erotic C	ardio-		Interval Between Onset and Death
		DUE TO (OR AS A CON		calar C			
CERTIFICATION	Sequentially list conditions, b.	DUE TO (OR AS A CON		Coller C	horase		
ξl	if any, leading to immediate cause. Enter UNDERLYING		occount or j.				i
ᇤ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CON	SEOUENCE OF):				
ᇤ	resulting in death) LAST						
	PART II. Other significant conditions	and the state of t	A consideration				
CAL	TAIT II. Other significant conditions	contributing to death but no	ic readiting in 1	ie underlying cause given i	n Part I. 24a, WAS, PERF	ORMEO?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
PHYSICIAN: MEDIC					1 _ YES	2 NO	OF DEATH?
Σ	DID TOBACCO USE CONTRI	DUTE TO CAUSE OF D	ATLL VEC				1 TYES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL		ACE OF DEATH (
200	EXAMINER?	HOSPITAL:	01	HER:	1 m 200 2000		
¥	27. MANNED OF DEATH	28a. DATE OF INJURY	28b. TIME OF	Nursing Home 5 Residence	28d. DE\$CRIBE HOV	V INJURY OCCUR	FD
	1 Natural 5 Pending	(Month, Day, Year)	INJURY	WORK? M 1 YES 2 NO	200. 0200.102.110		
BÁ	2 Accident Investigation 3 Suicide 6 Could not be	280. PLACE OF INJURY — At	home, ferm, atree		281. LOCATION (Street	et and Number or F	Rural Route Number,
COMPLETED	4 Homicide determined	building, atc. (Specify)			City or Town, Sta	te)	* · · · · ·
ן ב	29e. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the best of my knowledge,	death occurred at	the time, data and place, and di	se to the ceuse(s) and n	enner es stated	
S		On the basis of examination and/					suse(s) and menner as atated.
	206. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE N			GNED (Month, Day, Year)
BE (Cartan	rau		DA	10354	> /	125795
2	ON NAME AND ADDRESS OF PERSON WHO O	mara MD	TEM 27) (Type, Prin	nester town	md.	21620	
	31. DATE FILED (Month, Day, Year)	12. REGISTRAR'S SIGNATURE	1.00	1001 (1 1000)	1, 10	21000	
- / 1	JAN 31 '95	grane variason-Man	lange.				

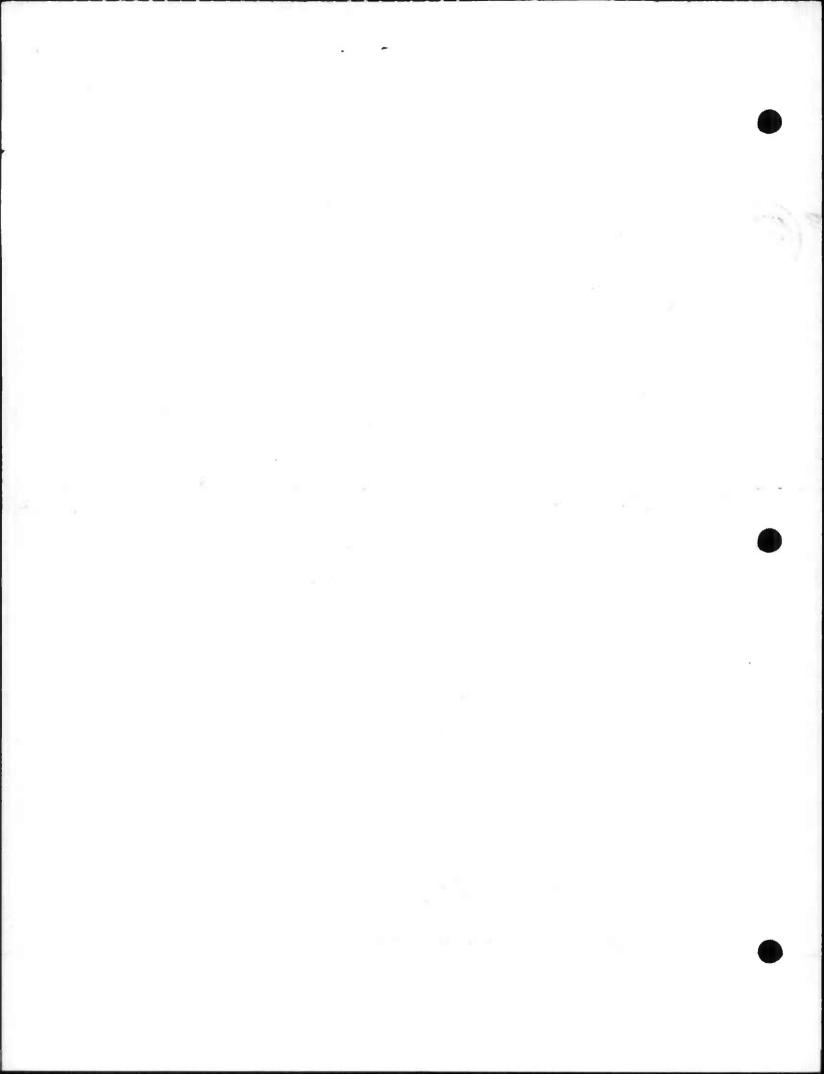
TO BE COMPLETED BY FUNERAL DIRECTOR

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	BOX	
	P.O.	
	RECORDS,	
	- VITAL R	
	OF	
	DIVISION	

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR	STATE OF MARYL		ENT OF HEALTH AND	MENTAL HYGIEN		
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
ANI	NA COOK WILL	IS		January 9	1995	FAR
4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. lest birthday)	UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign
215 20 1277	1 □ M 2 □ F 85		THE DAYS HOURS MIN.	(Month, Day, Year)		Country)
9a. FACILITY NAME (If not institution, give s	2411	06	CITY, TOWN OR LOCATION OF D	July 21,	9c. COUNTY	
At Home 249 Fey	Road	JRF	D Chestertown	21620	Queen	Anne County
10a. STATE 10b. COUNTY	,	10c. CITY, TO	WN OR LOCATION			10d, INSIDE CITY
Maryland Queen	Anne Co.	RFD C	hestertown (5	19 Fey Road	1)	LIMITS?
10e. STREET AND NUMBER	221110 001	ILI D	101. ZIP CODE	77 Tey Road		OF WHAT COUNTRY?
RFD 549 Fe	v. Pood		21620			OF WHAT COUNTRY?
44 14401741 074710					USA	
1 Never Married Widowed	12. WAS DECEDENT EVER I FORCES? 1 YES	2 NO	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic		a or No- 14.	RACE — American Indian, Black, White, atc.
3 ₩idowed 4 Divorced	IF YES, GIVE WAR OR D		1 YES 2 NO Speci			Specify:
45 0505050470 500	ATION!	No		No		White
15, DECEDENT'S EDUC (Specify only highest grade	completed)	16a. DECEDENT'S USU (Give kind of work	done during most of working	16b, KIND OF BU	SINESS/INDUS	TRY
Elamentary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT usa ret	•		1	
i i		Secretary		Auto Sa	ales Ag	gency
17. FATHER'S NAME (First, Middle, Last)		(an)	16. MOTHER'S N	AME (First, Middle, Maiden	Sumame)	
H	arry C. Cole	man (SR)	Eliza	oeth Ivens		
19a. INFORMANT'S NAME (Type/Print)	31 0. 1	19b. MAILING ADD	PRESS (Street and Number or Rural	Route Number, City or Tox	n, State, Zip Co	de)
Wm. Barney Will	is III	616 Cen	tral Drive C	nestertown	, Md. 2	21620
20a. METHOD OF DISPOSITION D	urio1 200	. PLACE AND DATE OF DI	SPOSITION / Name of	DATE 20c. LC	CATION — City	or Town, Stata
20a. METHOD OF DISPOSITION 10 Buriel 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	Wall World State Cer	netery, crematory or other p	place)	1		
21. SIGNAPORE OF FUNERAL SERVICE LIC		hester Cem	22. NAME AND ADDRESS OF F			vn, Md.
1.00	1 1 /	h			413 Hi	igh St. 21620
1 Willi	is (NOV	11/	Fellows - Well	ls	Chant	ertown Md. 914
23. PART I. Enter the diseases, or o	omplications that cause	d the deeth. Do not e	enter the mode of dying, au	h ea cerdisc or reap	iratory arrest	Approximate
shock, or heart fellure.	List only one cause on a	ech line.				Interval Between Onsat and Death
disease or condition	C		1 61			
resulting in death)	DUE TO OR AS	tive hea	irt tailure			8 yrs.
	mal	CONSEQUENCE OF):				
Sequentially list conditions,	a Trick	CONSEQUENCE OF):				
If any, leading to immediate cause, Enter UNDERLYING	DUE TO (ON AS A	CONSEQUENCE OF):				i 1
CAUSE (Diseese or Injury						
that initiated evente resulting in deeth) LAST	DUE TO (OH AS A	CONSEQUENCE OF):				
	l					
PART II. Other algolificent condition	e contributing to death it	out not resulting in th	e underiving cause given in	Part I. 24s. WAS AN	VARITIAL	24b. WERE AUTOPSY FINDINGS
1 0 0		at the teaching in the	o directlying cause given in	PERFO		AVAILABLE PRIOR TO
	llation			1 YES :	2 DAG	COMPLETION DF CAUSE DF DEATH?
	ascular di					1 TES 2 NO
DID TOBACCO USE CONTI	RIBUTE TO CAUSE C	F DEATH YES	☐ NO ☐ UNCERTAI	N 🗆		
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (C	heck only one)			
1 TES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Out		HER: Nursing Home 5 Manidenca	8 Other (Specify)		
27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME OF	28c. INJURY AT	28d. DESCRIBE HOW	NJURY OCCUR	ED
1 Natural 5 Pending	(Month, Day, Year)	INJURY	M 1 YES 2 NO			
2 Accident Investigation						David Charles March
a C Autora	28e, PLACE OF IN HIRV	— At home form street	tectory office	201 LOCATION (O	and Muchanic	
3 Suicide 6 Could not be	28e. PLACE OF INJURY building, atc. (Spe	' — At homa, farm, street	, tactory, offica	281. LOCATION (Street City or Town, State,		nurar noute number,
3 Suicide 6 Could not be datarminad	28e. PLACE OF INJURY building, atc. (Spe	— At homa, farm, street	, tactory, offica			nurai rioute Number,
3 Suicide 6 Could not be datarminad 29a. CERTIFIER (Check only)	building, atc. (Spe	effy)	, tactory, office	City or Town, State,		нигат ноисе митоег,
3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) CERTIFYING PHYSIC	CIAN: To the best of my know	olly)		City or Town, State,	nner an stated.	
3 Suicide 6 Could not be datarminad 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINED	CIAN: To the best of my know	olly)	the time, data and place, and during opinion, death occured at the	City or Town, State, to the cause(a) and ma time, data and placa, ar	nner as stated,	suse(a) and manner as stated.
3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) CERTIFYING PHYSIC	CIAN: To the best of my know	olly)	the time, data and place, and dui my opinion, death occured at the 29c. LICENSE NU	City or Town, State, to the cause(a) and matime, data and place, and	nner as stated. Indidua to the ci	suse(s) and manner as stated. GNED (Month, Day, Year)
3 Suicide 4 Homicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER	Dullding, stc. (Spe CIAN: To the best of my know 3: On the basis of examinatio	elegs, death occurred at n and/or investigation, in	the time, data and place, and during opinion, death occured at the 29c. LICENSE NU $D\!-\!3351$	City or Town, State, to the cause(a) and matime, data and place, and	nner as stated. Indidua to the ci	suse(a) and manner as stated.
3 Suicide 4 Homicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	DIAN: To the best of my know	ledge, death occurred at n and/or investigation, in	the time, data and place, and during opinion, death occured at the 29c. LICENSE NU D-3351	City or Town, State, to the cause(a) and matime, data and place, and	nner as stated. Indidua to the ci	suse(s) and manner as stated. GNED (Month, Day, Year)
3 Suicide 4 Homicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINET 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO Michael Bienenf	CIAN: To the best of my know R: On the basis of examination COMPLETED CAUSE OF DE eld Chest	elegs, death occurred at a n and/or investigation, in and/or investigation and investigat	the time, data and place, and during opinion, death occured at the 29c. LICENSE NU D-3351	City or Town, State, to the cause(a) and matime, data and place, and	nner as stated. Indidua to the ci	suse(s) and manner as stated. GNED (Month, Day, Year)
3 Suicide 4 Homicida 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINEI 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	CIAN: To the best of my know	elegs, death occurred at a n and/or investigation, in and/or investigation and investigat	the time, data and place, and during opinion, death occurred at the 29c. License NU D-3351	City or Town, State, to the cause(a) and matime, data and place, and	nner as stated. Indidua to the ci	suse(s) and manner as stated. GNED (Month, Day, Year)



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BALTIMORE, MARYLAND 21215-002	nin 24 hours after death. Page 6 may be retained by the hospital or attending in	tely filled in by the funeral director, page 5 should be detached for use as the mation, or removal.	t, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or arternating pre-	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use an the burla, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARY		RTMENT OF I		REG. NO.	_	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATN
	Glendal Edw	ards		Whi-	te-	January:		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AG	E (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	DATE OF BIRTH	8. BIR	THPLACE (State or Foreign
	224-20-5342 9a. FACILITY NAME (If not institution, give:	1 M 2 XF	71 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 12/30/192		th Carolina
OR	PENINSULA REGION	A COLUMN TO THE OWNER OF THE OWNER	ENTER		OR LOCATION OF DEA	ATN	9c. COUNTY OF WIC	OMICO
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT						I	
DIRECTOR				Y, TOWN OR LOCA				10d. INSICE CITY LIMITS?
	Maryland Somer	set	Pod	comoke C				1 TES 2 THO
FUNERAL	34042 Clearfield	Poad		10	21851		1,10	WHAT COUNTRY?
<u> ۲</u>	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13 WAS DEC		C ORIGIN? (Specify Yes	USA	CE — American Indian,
	1 Never Married 2 Married	FORCES? 1 YE	S 2 XNO	If yes, sp	ecify Cuban, Maxican 2 XNO Specify:	, Puerto Rican, atc.)	Bia	ick, White, atc.
B	3 Widowed 4 Divorced			1 120	2 Kino specify:		Spi	white
	15. OECEDENT'S EDU (Specify only highest grade	JCATION e completed)	16a. DECEDENT'S	USUAL OCCUPATION	ON ast of working	16b. KINO OF BUS	INESS/INDUSTRY	
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT us	se retired.)	or or worlding			
COMPLET	12		homemal	cer				
	17. FATNER'S NAME (First, Middle, Last)					NE (First, Middle, Maiden	Sumame)	
H	Charles D. Edward	ds			Bertha L			<u> </u>
임	.,,,	h a				oute Number, City or Town		
	Frederick L. Whit					ocomoke, l		
	1 Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	novel from State	ob. PLACE AND DATE (ther place)			CATION — City or	
	21. SIGNATURE OF FUNERAL SERVICE LIN	CENSEE	itts Creek	22. NAME AI	An Cereter	7 1/26 Poce	omoke Ci	ty, Ma.
	D. ALC	Man . O .			n Funeral			
	22 PAST I Este the discourse	meson		PO Box	x 64, Poc	omoke City	y, Md.	21851
	23. PART I. Enter the diseases, or shock, or heart failure.	List only one ceuse on	each line.	not enter the mo	de of dying, such	es cerdiac or respi	ratory srrest,	Approximate interval Between
	iMMEDIATE CAUSE (Finsi disease or condition	Van Jair	1 - 6%	: Haba				Onset and Death
l	resulting in death)	S. OUE TO (OR AS	A CONSEQUENCE OF	D:	7			10 ~1204
2		DUE TO (OR AS	cuhala	adly 2	. to ve	nt. Film	Ulakan	72 6000
HIFICATION	Sequentisity list conditions, if sny, leading to immediate	DUE TO (OR AS	A CONSEQUENCE O	7		40.1		(
<u>5</u>	CAUSE (Disesse or injury	- Coronay	Arten	Diseas	· bary	PYL		1 mark
	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF	F):	, 8			
		d						
ا پ	PART II. Other significent condition	ns contributing to deeth	but not resulting	in the underlying	cause given in P	Part i. 24s. WAS AN		b. WERE AUTOPSY FINDINGS
<u> </u>						PERFOR 1 TYES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDI						_	E NO	OF DEATH? 1 ☐ YES 2 📝 NO
	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH YE	S NO [UNCERTAIN			· · · · · · · · · · · · · · · · · · ·
¥	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT					
2	1 TES 2 NO	HOSPITAL:	tpatient 3 DOA	OTHER: 4 Nursing Hom	e 6 🗆 Rasidence 8	☐ Other (Specify)		
PHYSICIAN:	27. MANNER OF DEATH 1 Natural 6 Pending	26a. DATE OF INJURY (Month, Day, Year)		E OF 28c, INJ URY WO	URY AT	28d. DESCRIBE HOW IN	JURY OCCURED	
5	1 Natural 6 Pending 2 Accident Investigation				rES 2 NO			
3	3 Suicide 6 Could not be 4 Homicide detarmined	26e. PLACE OF INJUI building, atc. (Sp	TY — At home, farm, s ecify)	street, factory, offic	'	26f. LOCATION (Street a City or Town, State)	nd Number or Rural	Route Number,
COMPLEIED	29s. CERTIFIER							
Ž.		ICIAN: To the best of my kno ER: On the basis of axaminat						
			on and of investigatio	n, in my opinion, d				
	296. SIGNATURE AND TITLE OF CERTIFIE	. 01			29c. LICENSE NUMB			23.95
2 ∦	30. NAME AND ADDRESS OF PERSON WN	O COMPLETED CAUSE OF F	FATN (ITEM 27) /F	Print)	DYYO	64		-2.47
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	31. DATE FILED (Month, Day, Year)						0 -1	
	LAN / IUUL	1. 1						

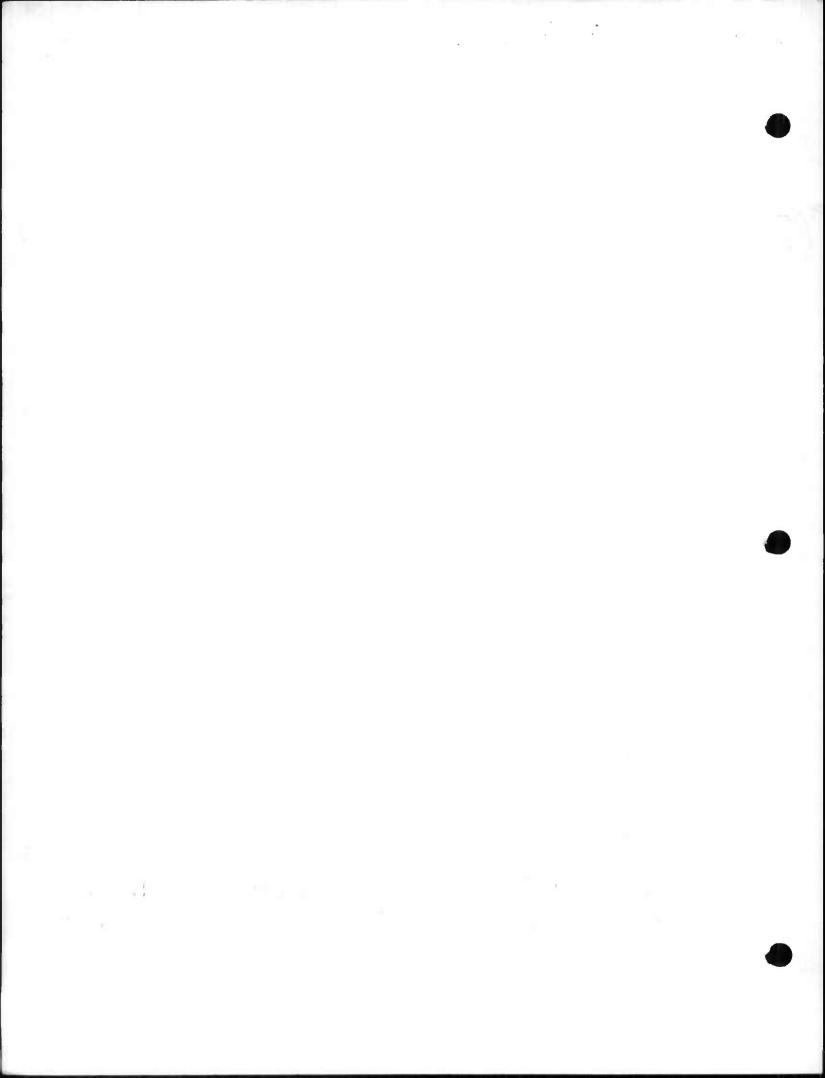
purhable services. AND ALL STATES and program of the second

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 28 frout after these 6 may be retained by the attending physician and completely filled in by the functor, page 6 should be desired be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or temberal.

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1	FOR STATE REGISTRAR	STATE	OF MARYLAND / DEPAR	TMENT OF H		MENTAL HYGI	
1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	1
L	Grace Ellen We	ells				монтн 2	DAY 4
4	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	

- 8	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF				3. TIME OF DEATH
	Grace Ell		lls							монтн 2	D.	1	95	6:30 P M
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER		IF UNDER		7. DATE OF I			8. BIRTI	IPLACE (State or Foreign
	214-32-709		1 🗆 M 2 💢 F	90	YRS.	MONTHS	DAYS	HOURS	MIN.	9/10			Count	"MD
	90. FACILITY NAME (If not in	nstitution, give s	treet end number)			9b. CITY	, TOWN (OR LOCATI	ON OF DE		,	9c. COU	NTY OF D	
DIRECTOR	11636 W	orcest	er Highv	vav			Sho	owell				Wo	rces	ter
5	RESIDENCE OF DEC	10b. COUNTY										1110	ii ccs	otei
2	MD MD		orcester		10c. CIT	Y, TOWN	R LOCAT							10d. INSIDE CITY LIMITS?
	40. 070077 440 4444													1 TES 2X NO
FUNERAL	10e. STREET AND NUMBER						101	. ZIP CODI	E			10g. CIT	IZEN OF V	WHAT COUNTRY?
W		orcest	er Highv						1862				US	4
	11. MARITAL STATUS 1 Never Merried 2	Merried	FORCES?	T EVER IN U.S. AF	MED	13.	WAS DEC	ENDENT C	F HISPAN	IC ORIGIN? (S	pecify Yes	or No-	14. RACE Black	E — Americen Indian, k, White, etc.
B	3 Widowed 4 Divo		IF YES, GIVE V	MAR OR DATES			YES	2 💢 NO	Specify	:			Speci	∞ white
E	15. DEC	EDENT'S EDUC	CATION	16a, DE	CEDENT'S	USUAL O	CCUPATIO	ON		16h KIN	D OF BUS	INESS/ING	DUCTOV	
	(Specify only Elementary/Secondary (0	y highest grade	completed) College (1-4 or 5	(G	ive kind of a Do NOT us	work done	during mo	st of workin	g	I I I I I I I I I I I I I I I I I I I	0 01 000	MACOOINA	JOSINI	
릴		/	- Д		each	er				E	Educ	atior	1	
COMPLET	17. FATHER'S NAME (First, M	liddle, Last)						18. MOTH	IER'S NAI	ME (First, Middl	e, Malden	Sumame)		
BE C	Peter O	tis Ra	yne							Floren			/	
	190. INFORMANT'S NAME (7	,,		19	b. MAILING	ADDRESS	(Street a			loute Number, C			,	
2	Mary Eller	Crop	per							Newa			2184	41
	20a. METHOD OF DISPOSIT			20b. PLACE	ANDDATE	OF DISPOS	ITION (Na	ma of		DATE	20c. LO	CATION —	City or To	wn, State
	4 Donation 5 D Other	(Specify)	DVIII ITOM STREE	cemetery, cre Trini	matory or o	_{ther placa)} arde	n of	f Mer	nor√	7/95	Ne	wark	, MI	D
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE	Q 1		22.	NAME AP	ND ADDRES	S OF FAC					
	· W	· X	uk	Dut	age		108	Willi	iams	st. B	erlir	e ru n. M	nera D 2	l Home
	23. PART I. Enter the di	isesses, or c	complications the	it causad the da	ath. Do r	not antar								Approximate
	immediate cause (Fin	aart tailura.	List only one can	usa on asch lina										Interval Between Onset and Death
1	disease or condition		a. Prob	ble P		Made	ue							
i	rosuning in deatil)		DUE TO	(OR AS A CONSE	DUENCE OF	F):								
Z	Sequentially list conditi		. Chur	ne um	impl	rele	9							
CERTIFICATION	If any, leading to immed	diata	OUE TO	(OR AS A CONSE	DUENCE OF	F):					_			
5	cause. Entar UNDERLYi CAUSE (Disease or inju	iry 4	CHE	(OR AS A CONSEC										
	that initiated events resulting in death) LAS	т .	100E 10	OR AS A CONSEC	DUENCE OF	F):								
岁 1			d. (VDIV											
	PART II. Other significa	nt condition	a contributing to	death but not r	eaulting I	n tha un	dariying	causa g	ivan in I	Part i. 24a	. WAS AN		24b.	WERE AUTOPSY FINDINGS
MEDICAL			_								PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
				_						_ ' '] 1E9 2	Z NO		OF DEATH?
										-				1 - YES 2 NO
Ž	25. WAS CASE REFERRED TO	O MEDICAL		GMO	-		26. PL	ACE OF DE	EATH (Che	ck only one)				
PHYSICIAN:	EXAMINER?		HOSPITAL:	ER/Outpetlant 3	DOA	OTHER 4 Num	t:			8 Other (Sp	0.016.1			
<u>}</u>	27. MANNER OF DEATH		28e. DATE OF	INJURY	26b. TIM	E OF	28c. INJ	URY AT	T	26d. DESCRIE		JURY OC	CURED	
ВУР		Pending Investigation	(Month, D	Pay, Year)	INJ	URY M		RK? 'ES 2 [NO					
- 10	2 0 0 1 1 1 1 1	Could not be	28e. PLACE O	F INJURY — At ho etc. (Specify)	me, farm, s	dreet, facto	ory, office			281. LOCATIO		nd Number	or Rural F	loute Number,
<u> </u>	4 Homicide	determined	bulleting,	ore. (Specify)						City or Tox	wn, State)			
7 [29a. CERTIFIER 1 CERT	IFYING PHYSIC	CIAN: To the best of	my knowledge, de	ith occum	d at the ti	me, date	end place	and due	to the cause(s)	and man	nor an elet	ad .	
COMPLETED) end menner as stated,
	256. PHOMATURE AND TITLE					-			NSE NUM		1			(Mgnth, Day, Yeer)
H	now hu	M	()					44	361	7		DAI	215	- S
유	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF DEATH (ITER	4 27) (Type.	Print)		11.1	701	J			210	110
_	Scott A.S	VILLO C	ne no) 3	314	FR	AN	KLI	N.	MF.	P	207	116	MA
71	31. DATE FILED (MODELL Day,	100 y	32. REGISTRA	AR'S SIGNATURE	- 1	_	,			, - 0	4.	40	011	21811
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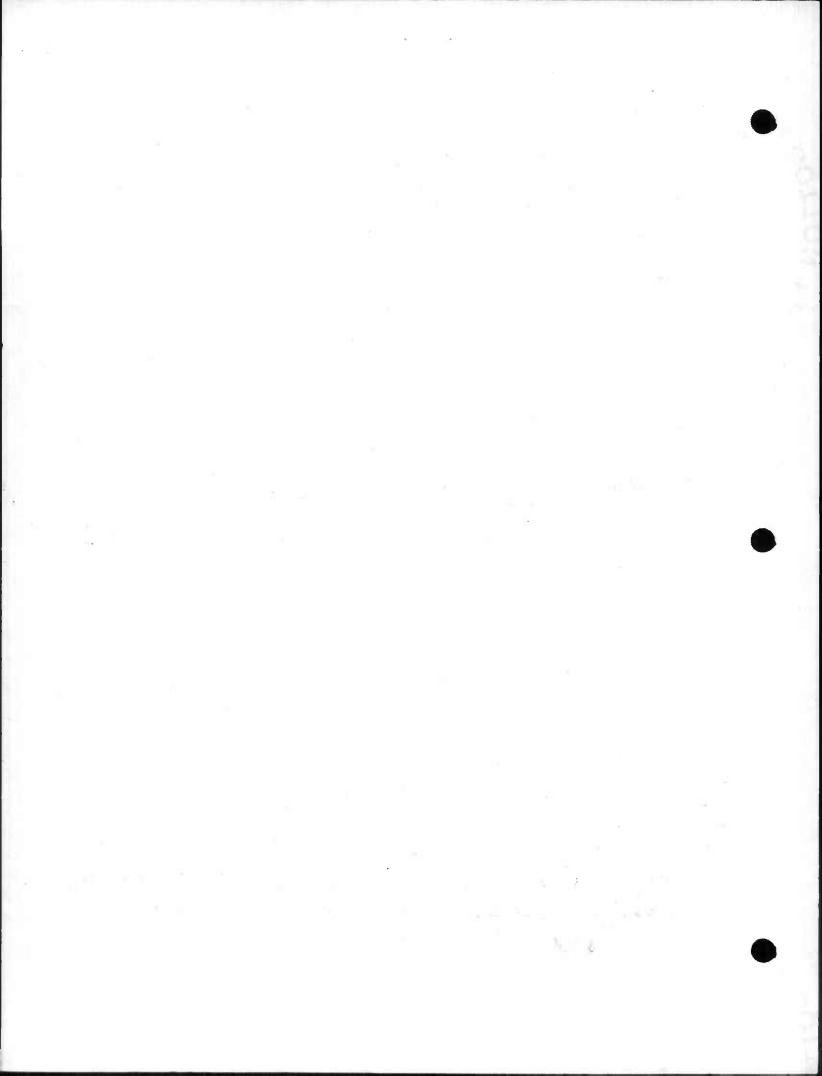


FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OFATH Hilda 1 95 1:00 P M White 7. DATE OF BIRTH (Month, Day, Year) Nov. 27, 1911 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 F 83 Preston, MD. 03-9845 Se. FACILITY NAME (If not institution, give street end number 9b, CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR Meridian - The Pines Easton Talbot RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD. Caroline Federalsburg 1) YES 2 | NO 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 111 Reliance Auneue 21632 USA 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Merried 2 Merried BALTIMORE, MARYLAND 21215-003 specify: White 3 Widowed 4 Divorced 1 TES 2 NO Specify: BY hospital or attending 12 COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY 85 (Specify only highe B Elementary/Secondary (0-12) College (1-4 or 5+) 12 detached Secretary 0 Banking once. 17. FATHER'S NAME /First Middle Last 18. MOTHER'S NAME (First, Middle, Maiden Surneme) retained by the 8 T Edward Plutschak BE Auguste Kleinschmidt funeral director, page 5 should notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Janice Plutschak Mapleton Street, Hurlock, MD. 21643 102 ours after death. Page 6 may be 90 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Burlei 2 Cremetion 3 Re elery cremetory or other place) Hillcrest Cemetery Donation 5 - Other (Specify) _ 1/27/95 Federalsburg, MD 21. SIGNATURE DE MINERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Williamson Funeral Home filled in by the foundation. Federalsburg, MD medical 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such ea cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximata Interval Between 00 IMMEDIATE CAUSE (Final Onset and Death npletely filled cremation. event, the disease or condition -UMPHOMA resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 executed with in and comp traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) attending physician a ental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING requires that the death certificate be CAUSE (Disease or injury other OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 0 n signed by the attend Health and Mental H Injury, PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY эпу 1 YES 2 NO OF DEATH? shows a 1 TYES 2 NO been of of s certificate has ber th the State Dept. 1 PHYSICIAN: WE 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

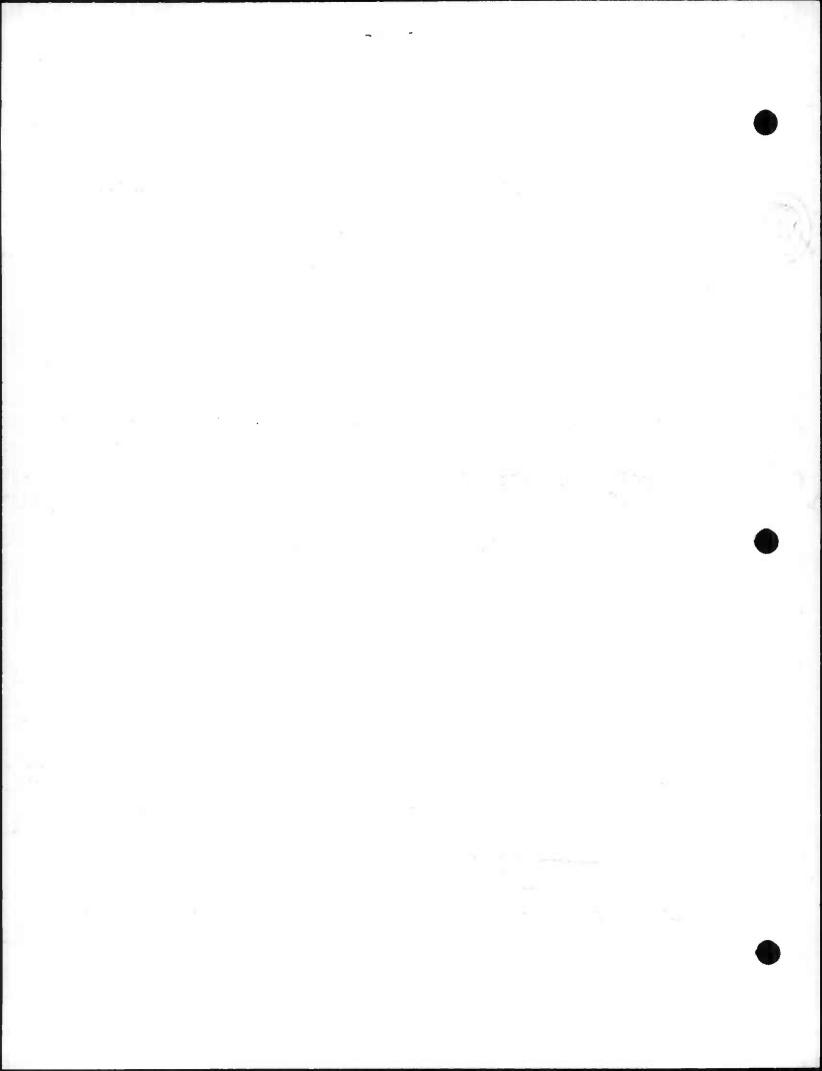
1 YES 2 ND 26. PLACE OF DEATH (Check only one) HOSPITAL OR ATTENDING PHYSICIAN: The HOSPITAL OTHER: ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME O 28d, DESCRIBE HOW INJURY OCCURED with t marked, 1 Natural
2 Accident 5 Pending Investigation 1 YES 2 NO BY After death 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 3 Sulcide 281, LOCATION (Street end Number or Rural Route Number, City or Town, State) 649 8 Could not be DIRECTOR: Nours after of COMPLETED 28 4 Homicide Hem 29e, CERTIFIER CERTIFYING PHYSICIAN: To the beat of my kno FUNERAL (= TO THE HOSPITA
TO THE FUNERA
DE filed within 72
IMPORTANT: I MEDICAL EXAMINER: On on, in my opinion, death occured at the time, date and place, end due to the ceuse(e) end menner ea stated. NATURE AND TIT 29c. LICENSE NUMBER 29d. DATE SIGNED (Mont). Day, BE 2 LETED CAUSE OF DEATH (ITEM 27) (Type, Print) et ko

32. REGISTRAR'S SIGNATURE

- 3 1995



		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND /	DEPAR	TMENT OF	HEALTH AND F DEATH	MENTA	L HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last) CHRISTOPHER	E	Ξ.		WOOD	RUFF	J AN	OF DEATH	26 19	79 5 3.	TIME OF DEATH 11:05 P
P		4. SOCIAL SECURITY NUMBER 225-23-0817	1 XM 2 F	(In yrs. lest	t birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS		7. DATE (Mon	th, Day, Year)	1977	BIRTHPLA Country) Was	NCE (State or Foreign
pinous &	TOR	PAL FACILITY NAME (If not institution, give st PHYSICIAN MEMORESIDENCE OF DECEDENT		TAL			PLATA	DEATN		9c. COUNTY CHAI		N
(f)	DIRECTOR	10e. STATE 10b. COUNTY	arles			y, TOWN OR LOC	Plains					d. INSIDE CITY LIMITS?
	FUNERAL	100. STREET AND NUMBER 4013 Spring Va					101. ZIP CODE 20695					T COUNTRY?
21215-0020 al or attending physician. for use as the burial-tran	ΒY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D.	2 X N	WED O	If yes,	ECENDENT OF NISP/ apacity Cuben, Mexic ES 2 NO Spec	en, Puerto	N? (Specify Yes Rican, atc.)	or No 14	RACE - Black, W Specify: Whi	
ND 21215 hospital or attend ached for use as	PLETED	15. DECEOENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5 +)	(Gh	EDENT'S We kind of v Do NOT us		TION most of working	16	b. KIND OF BUS	SINESS/INDUS		
YLA by the be def	ш	17. FATHER'S NAME (First, Middle, Last) Robert E. Wo	odruff		cuue	-110	16. MOTHER'S N	AME (First,	,	sumame) hea		
RE, MARYL ay be retained by the page 5 should be of the notified at of	TO B	190. INFORMANT'S NAME (Type/Print) Robert E. Wood 200. METHOD OF DISPOSITION				Gall	Gallahan Rd. Clinton, Maryland 20 Sposition (Neme of OATE 2006, LOCATION — City or Town, State, Zip Code)					
6 m ector,		1 X Buriel 2 Cremetion 3 Remo	oval from State Gen	PLACE A	nd date on the nation of the n	n Nat	ional C	em2/	1 Sui	tland	y or Town,	aryland
death. death. e funeri		Benjamin M.		J ₀₆		The P.O	Huntt box 1	Fune 56 W	aldor	f, Ma	ryl	and 2060
within 4 hours within 4 hours hipletely filled in to cremation, or re-		23. PART I. Enter the diseasea, or c shock, or heart feilure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause on e	ech line.				ch aa car	dlec or reapi	retory arrea	ι,	Approximate Interval Between Onset and Death
P.O. BOX 687, the certificate be executed ending physician and con i Hygiene prior to burial, or other traumatic e	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	OUE TO (OR AS A									
ORDS, that the deal ed by the ath th and Menta any injury,	EDICAL C	PART II. Other algnificant conditions	contributing to death b	ut not re	esulting i	n the underly	ing ceuse given in	Part I.	24a. WAS AN PERFOR	MED?	CO OF	RE AUTOPSY FINDINGS ILLABLE PRIOR TO MPLETION DF CAUSE DEATH?
Sept as	SICIAN: M	DID TOBACCO USE CONTR				S NOV		IN 🗆			17.	YES 2 NO
- F 2 6 5	PHYSIC	EXAMINER? 1 TYES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 Inpatient 2 XER/Outp 28e. OATE OF INJURY		DOA 28b. TIMI	OTHER: 4 Nursing No	ome 5 - Residence	_	er (Specify) \$CRIBE HOW IP	NJURY OCCUP	IED - a a	6 6011 340
After the death of mark	ED BY P	1 Natural 5 Pending Investigation 3 Suicide a Could not be determined	(Month, Day, Year) - 2.6 28e. PLACE OF INJURY building, atc. (Spec	:Hy)	0	o M 1 [YES 2 NO		CATION (Street a or Town, State)	note 1	Pural Route	Number,
AL OR AL DIR	COMPLET	29a. CERTIFIER (Check only 1 CERTIFYING PNYSIC	DIAN: To the best of my knowl	ledge, des	th occurre			e to the ce				ires Co.
TO THE HOSPITAL TO THE FUNERAL be fied within 72 IMPORTANT: If	BE COI	29b. SIGNATURE AND THELE OF CERTIFIER	2: On the besis of examination	n snd/or Ir	rveatigation	n, in my opinion.	29c. LICENSE NU O . C . M .	MBER	end place, and	29d, DATE S	IGNED /Mo	onth, Day, Year)
C C a	10	30. NAME AND ADDRESS OF PERSON WHO DOVID R RU					et, Bal		ore, N			



3. TIME OF DEATH

2. DATE OF DEATH

CLARA REVAUDA WEAVER 6:30 Jan. 1995 2, 3 should 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 M 2 X I 217-14-2978 YRS. 72 April 10.1922 North Carolina as. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 3056 Harmony Church Rd. Darlington Harford RESIDENCE OF DECEDENT ION COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Harford Darlington I TES 2 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3056 Harmony Church Rd. 21034 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 27 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No**burial-**1 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 physici If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 Never Married 2 2 Married IF YES, GIVE WAR OR DATES 1 - YES 2- NO Specify BY Specify: 3 Widowed 4 Divorced ours after death. Page 6 may be retained by the hospital or attending funeral director, page 5 should be detached for use as the White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William Glenn 70 Fender Ethel Revauda Jennings BE notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Vernon L. Weaver 3056 Harmony Church Rd., Darlington, Md. 21034 pe 20a. METHOD OF DISPOSITION

1 M Burial 2 Cremation 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE must Cem. 4 Donallon 5 Other (Specify)
21. BIGNATURE OF FUNERAL SERVICE LICE Harmony Church 27-95 Darlington, Md. medical examiner 22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 50 W. Broadway St., Bel Air, Md. 21014 attending physician and completely filled in by the intra Hygiene prior to burial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate shock, or heart fellure. List pnly one cause on each line Intervel Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition NULTPLE MYELOMA event, recuiting in death) executed with DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE DE) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other the attending physical f DUE TO (OR AS A CONSEQUENCE OF). that initiated evente resulting in death) LAST 0 PART ii. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL signed by the any Health 1 YES 2 NO DE DEATHS shows a I YES 2 NO has been a PHYSICIAN: OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH_(Check only one) certificate to the State EXAMINER? HOSPITAL: OTHER I YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 0 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DEŞCRIBE HOW INJURY OCCURED this c marked. 1 Natural 5 Pending I YES 2 NO BY After 2 Accident Investigation 28a. PLACE OF INJURY - Al home, farm, streel, factory, office 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 Is 8 Could not be determined COMPLETED DIRECTOR: / 4 Homicide tem 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To Iha best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and menner as stated. FUNERAL C within 72 h HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: OF investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIE 29d. DATE SIGNED (Month, Day, Year) 20c. LICENSE NUMBER BE -60 D31775 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BEZ AR EDWARDS m

22. REGISTRAN'S SIGNAPURE

1995

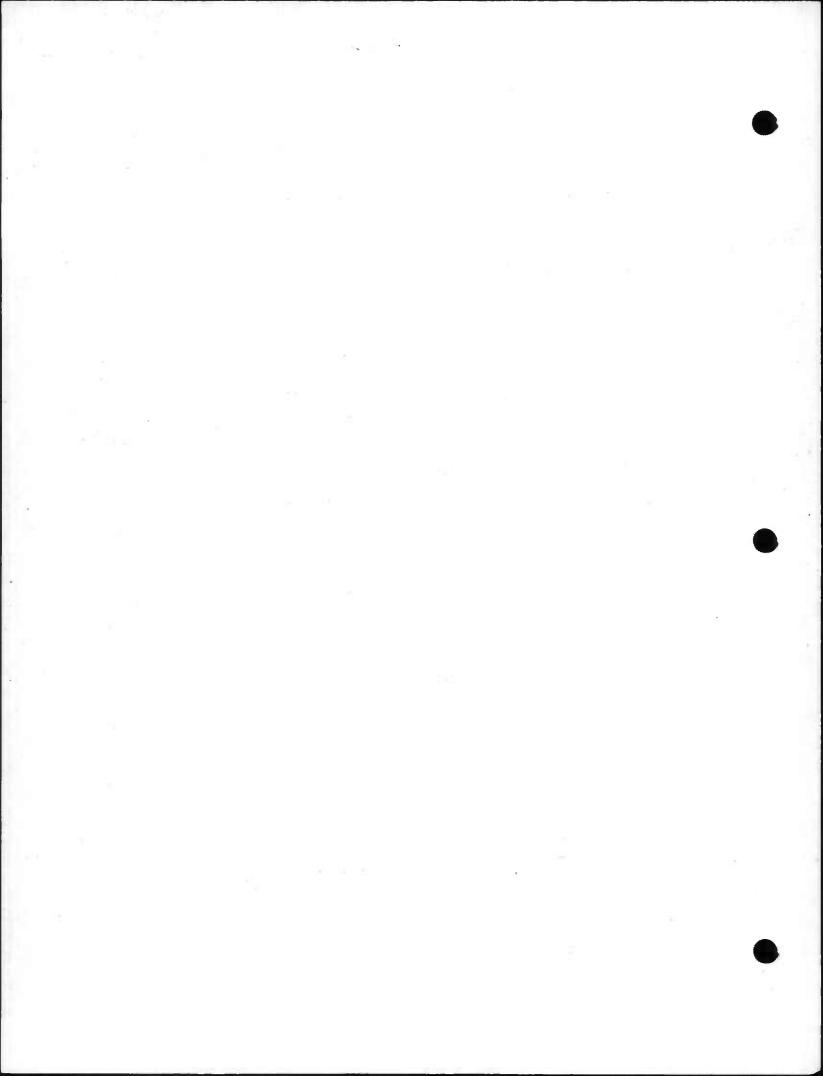
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

DHMH-16 Rev 1/89

2704



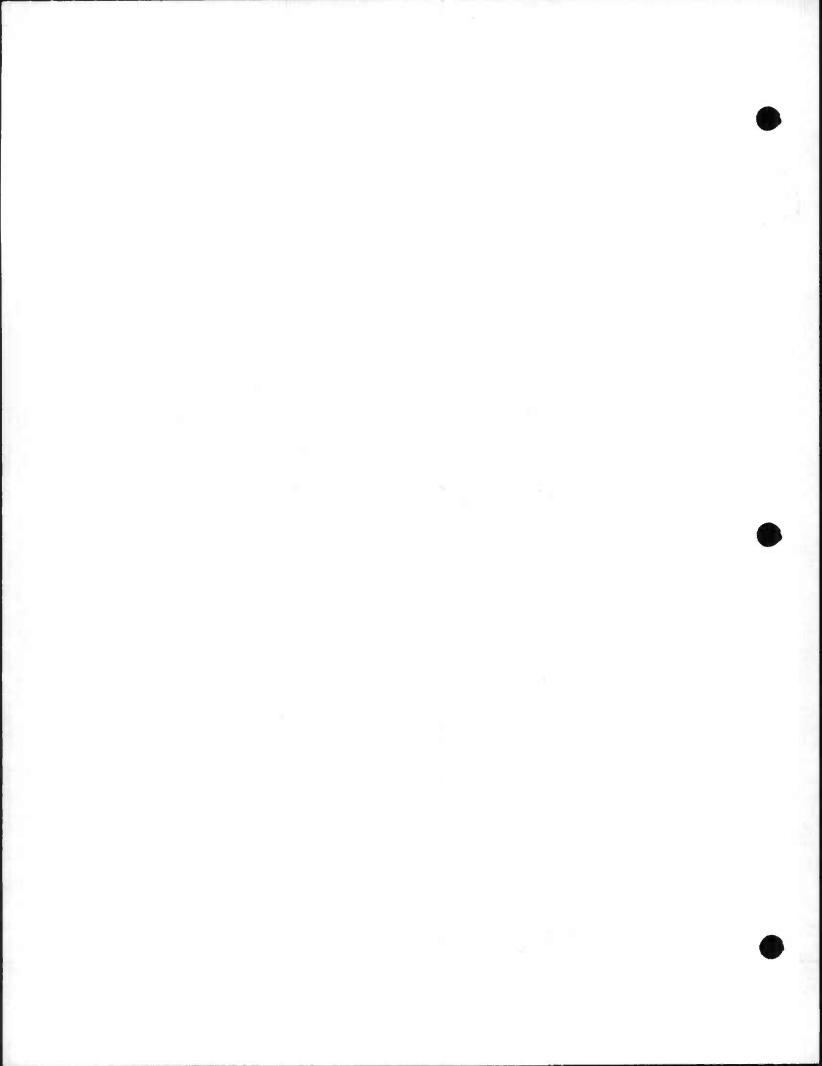
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Deor, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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10SP	UNER	ANT	
TO THE P	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept, of Health and Mental Hypiene prior to burial, cremation, or removal,	IMPORT	

	1 - FOR STATE REGISTRAR	STATE OF I		/ DEPAR					MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)	avis		Wal	Ke	_			2. DATE	OF DEATH		de la la la la la la la la la la la la la	3. TIME OF DEATH 2:30 PM
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs.	lest birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH		8. BIRTHP	LACE (State or Foreign
	217-12-1369	1) M 2 🗆 F	73	YRS.	MONTHS	DAY8	HOURS	MIN.		y 9,	1921	Country)	arvland
	Se. FACILITY NAME (If not institution, give				9b. CITY,	TOWN O	R LOCATIO	N OF DE		-3 / 3 -		NTY OF DE	
DIRECTOR	Shady Grove A	dventist	Hospit	al		Roc	kvil	le			Мо	ntgo	mery
Ä	10e. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWH O	R LOCATI	ION						10d. INSIDE CITY
	Maryland M	ontgomery	T			Dan	nascu	.5					LIMITS?
FUNERAL	10e. STREET AND NUMBER					10f.	ZIP CODE			· · · · · ·	10g. CITI	ZEN OF WI	HAT COUNTRY?
Ü	28001 Kempto	wn Church	Rd.				2	0872			Uni	ted :	States
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S.	ARMED	13. V	WAS DECE	ENDENT OF	HISPANI	C ORIGIN	? (Specify Yes	or No-	14. RACE	- American Indian, White, etc.
₩	1 Never Merried 2 Nerried 3 Widowed 4 Divorced	IF YES, OIVE V	WAR OR DATES				2 XNO			ricani, arcaj		Specify	
ED 8	15. DECEDENT'S EDU	W.W.			1								White
	(Specify only highest grade	completed)		OECEDENT'S (Give kind of life. Do NOT u	work done di	CUPATIO	N at of working	7	16b	KIND OF BUS	SINESS/IND	USTRY	
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5	+)		Realt	or			1	Real	Esta	te	
MO	17. FATHER'S NAME (First, Middle, Last)						18 MOTH	ED'S NAM	E /First 1	Middle, Maiden			
	Eugene S. W	. Walker					10. 110111			V. Da			
BE	19e. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	(Street an	nd Number (oer, City or Tow		Code	
5	Phyllis Stanley	Walker											Md. 20872
	20g, METHOD OF DISPOSITION		20b. PLAC	EANDDATE	OF DISPOSI	TION (Nar	me of	_	OAT			City or Tow	
	1 N Burlet 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	ioval from Stata	cemetery.	thesd:	ther place	hodi	st	2/10	1.				lle, Md.
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			22. N	NAME AN	D ADDRES	S OF FAC	ILITY			001	1101
	► (O/. · f.	201.	the							th, P.			- 0
	23. PART I. Enter the diseeses, or	complications the	t caused the	death Do	2	6401	Rid	lge R	ld.,	Damas	cus,	Md.	
	shock, or heart failure.	List only ons cer	ise on each i	ine.	not enter t	the mot	ae or dyin	ig, such	ss cerc	iisc or respi	ratory srr	est,	Approximate interval Between
	iMMEDIATE CAUSE (Final disease or condition	. Intra	1000	0 4	/	. 1							Onset and Death
	resulting in death)	OUE TO	(OR AS A CON	SEQUENCE O	EM 0	Ler	raje						1 Day
_					, ,.								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CON	SEOUENCE O	F):								
3	cause. Enter UNDERLYING CAUSE (Disease or injury	C											
E	that initiated events	DUE TO	(OR AS A CON	SEQUENCE O	F):								
15	resulting in death) LAST	d											
2	PART II. Other significent condition	ns contributing to	deeth but no	et resulting	in the und	derivina	csuse of	ven in P	Part I.	24s, WAS AN	AUTOPSY	24b. V	VERE AUTOPSY FINDINGS
. <u>১</u>	11	ron								PERFOR	MED?	1	WAILABLE PRIOR TO COMPLETION OF CAUSE
	3/					_			-	1 TYES 2	NO	9	OF DEATH?
2	DID TOBACCO USE CONT	RIBLITE TO CA	USE OF DE	-ΔTH YE	S D N	NO TO	LINCE	RTAIN				'	YES 2 NO
PHYSICIAN: MEDICA	25. WAS CASE REFERRED TO MEDICAL		_	ACE OF DEA			01102	-KIPGIT					
Sic	EXAMINER?	HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHER		5 🗆 Res	Idence 8	□ Other	(Specific)			
H	27. MANNER OF OEATH	28e. DATE OF	INJURY	28b. TIM	E OF	28c. INJU	JRY AT			CRIBE HOW II	NJURY OCC	URED	
	1 Natural 5 Pending	(Month, E	lay, Year)	IN	M	1 Y	RK? ES 2	NO					
Э ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE C	F INJURY — At	home, farm,	street, facto	ry, office			281. LOC	ATION (Street o	nd Number	or Rural Ro	ute Number,
	4 Homicide determined	bunding,	etc. (Specify)						City	or Town, State)			
	29a. CERTIFIER (Check only	ICIAN: To the best of	my knowledge.	death occurr	ed at the tin	ne, date e	end place.	end due to	o the cau	se(e) and man	one as elek	ad.	
1 2													end manner ee stated.
OMPLE		R: On the basis of e											
COMPLETED	2 MEDICAL EXAMINI 295 SIGNATURE AND TITLE OF CERTIFIE						29c. LICEN	USE NI IME	RER		20d DATE	SIGNED "	Month Day Vand
8	one) 2 MEDICAL EXAMINI		14 /	110			29c, LICEN	SE NUME	BER		29d. DATE	SIGNED (Month, Dey, Year)
	one) 2 MEDICAL EXAMINI	serbec	u /	UD	, Print)		DZ	-652	10		Fre	Gnay	7 1998
8	290- SIGNATURE AND TITLE OF CERTIFIE	serbec	u /	UD	, Print)		DZ	-652	10	Rol	Fre	Gnay	7 1998
8	290- SIGNATURE AND TITLE OF CERTIFIE	serbec 10 COMPLETEO CAU bock	u /	UD TEM 27) (Type:			DZ	-652	10	Pd.	Fre	Gnay	7 1998

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examiner must be notified at once.	TO BE COM
he medical	
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
IMPORTANT: If Item 28 is mark	TO BE COMPLETED BY

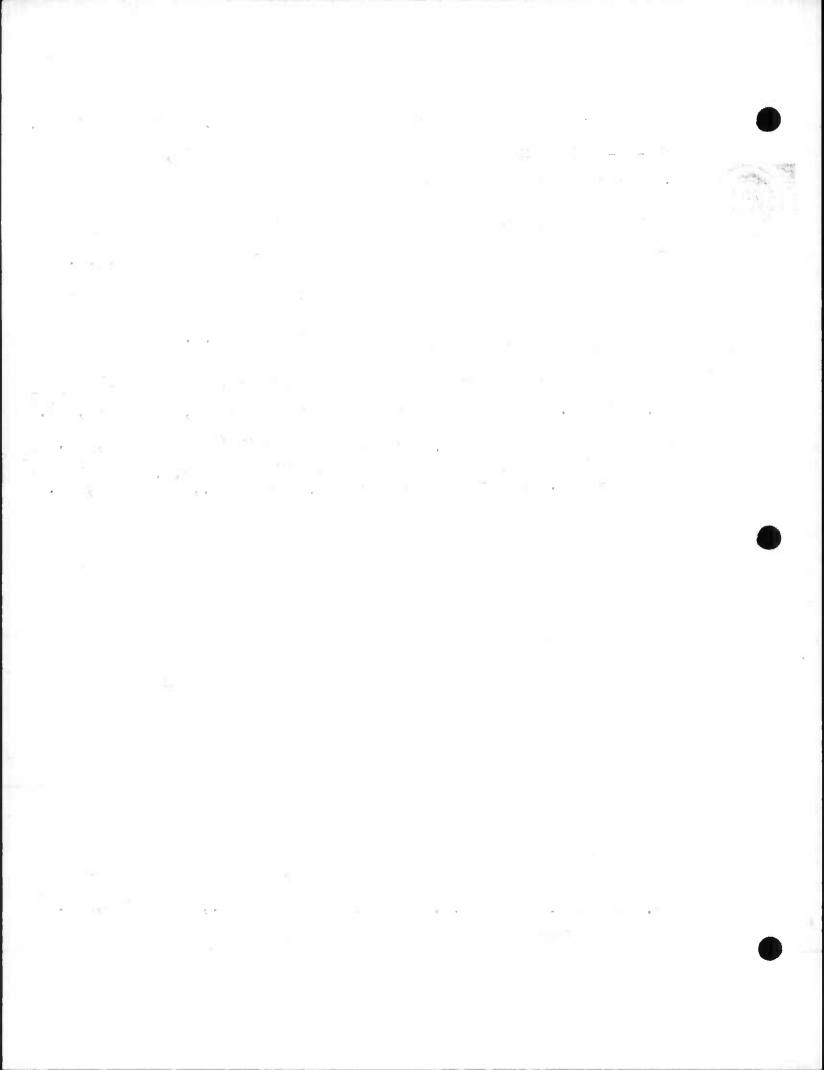
- 8	1. DECEDENT'S NAME (First	t, Middle, Last)							2. DATE OF DEATN			3. TIME OF DEATN
- 8	Jean F	airho	anks u	VALKER					February "	7 , 19	995	9'20A.H
- 8	4. SOCIAL SECURITY NUM		5. SEX	8. AGE (In yrs. less	birthday)	IF UNDER 1 YE	AR IF UND	R 24 HRS.	7. DATE OF BIRTH		8. BIRTH	PLACE (State or Foreign
- 1	064-12-7263	3	1 🗌 M 2 💢 F	82	YRS.	MONTHS DA	WS HOURS	MIN.	June 4, 19	912	Country	York
- 9	9e. FACILITY NAME (If not in	nstitution, give s	street and number)			9b. CITY, TO	WN OR LOCA	ION OF D			INTY OF D	
8	Frederick M	1emoria	al Hospit	al	- 1	Fre	deric	₹			rede:	
5	RESIDENCE OF DE	CEDENT					- COLIC			1	rede.	LICK
DIRECTOR	10e. STATE	10b. COUNT	•		10c. CITY,	TOWN OR L	OCATION					10d. INSIDE CITY LIMITS?
₽	Maryland		ederick			Frede	rick					1 XYES 2 NO
¥	10e. STREET AND NUMBER			_			10f. ZIP CO	DE		10g. CIT	IZEN OF W	HAT COUNTRY?
<u><u>u</u></u>	1473 West	Key E	Parkway,	Apt. B-3			2	1702			U.S.Z	Α.
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN U.S. ARI	MED	13. WAS	DECENDENT	OF NISPAI	IIC ORIGIN? (Specify Yes	or No-	14. RACE	- American Indien,
BY	1 Never Merried 2 3 Widowed 4 X Divo			MAR OR DATES			YES 2 X NO		n, Puerlo Rican, etc.)			, white, atc. White
												WILLE
COMPLETED	(Specify on	EDENT'S EDU y highest grade	completed)	(Gi	re kind of wo	SUAL OCCU	PATION g most of work	ing	16b. KIND OF BU	SINESS/INI	DUSTRY	
7	Elementary/Secondary (I	0-12)	College (1-4 or 5	+)	Do NOT use				Hon	10		
N N	47 CATHERIO MARIE (C) . 4		3+		cmema	ker						
8	17. FATNER'S NAME (First, M		DDG	III.			18. MO		ME (First, Middle, Maiden			
BE	19e. INFORMANT'S NAME (Jacob DEC						sie Gilber			VKS
9		,,							Route Number, City or Tow			
	Mrs. Mary A		one					ive,	Frederick,			
	20a. METHOD OF DISPOSIT	n 3 🗆 Rem	oval from State	20b. PLACE A cemetery, crem	natory or other	er nlane)					City or Tox	7-211.
1	4 ☐ Donation 5 ☐ Other 21. SIGNATURE OF FUNERA		CENCER	- Kensic	o Cem	netery	, Feb	.10,	1995 Valh	<u>alla</u>	, Net	w York
	A O O	E SERVICE EI	2 / A	^		Keen	ev & I	ess of fa	ord PA Fr	mera	1 Hor	mo l
	- All	an i	X Ru	by M	00703	106	East (Churc	rd P.A. Fu h St., Fre	deri	ck, N	4d. 21701
	23. PART i. Enter the d	seeses, or o	complications the	t caused the dec	th. Do no	t entar the	mode of d	ing, suc	h es cardiec or respi	ratory an	reat,	Approximate
	IMMEDIATE CAUSE (Fir		Liet only one cat	se on eech line.								Interval Between Onset and Death
	disease or condition resulting in deeth)	→		erehro	vale	la	G c	c. 1	-			
	,		DUE TO	(OR AS A CONSEQ	UENCE OF):							
Z	Compositelly list condition		b									ļ
CERTIFICATION	Sequentially liet condit if any, leading to imme	diete	OUE TO	(OR AS A CONSEO	UENCE OF):							
2	cause. Enter UNDERLY CAUSE (Disease or inju		с									
	thet initiated eventa resulting in death) LAS		DUE TO	(OR AS A CONSEO	UENCE OF):							
5			d									
	PART ii. Other aignifica	nt condition	s contributing to	deeth but not re	sulting in	the under	ying ceuee	given in	Part I. 24s. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
MEDICAL			Fort						PERFOR	MED?	3	AVAILABLE PRIOR TO COMPLETION OF CAUSE
요				.,,					1 YES 2	NHO		DF DEATN?
	DID TOBACCO U	SE CONTI	PIBLITE TO CA	LISE OF DEAT	H VEC		TX HAV	CEDTAIN			ı	1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO		NIBOTE TO CA			(Check only		LEKIAII	<u> </u>			
ဗ္ဗ	EXAMINER?		HOSPITAL:	ER/Outpatient 3		THER:		(
<u></u>	27. MANNER OF OEATN		28e. DATE OF	INJURY	28b. TIME	OF 26c	INJURY AT	emidence	6 Other (Specify) 26d. OESCRIBE NOW II	JURY OC	CURED	
	/	Pending Investigation	(Month, D	ay, Year)	INJUR		WORK? YES 2	NO				
BY	3 Devlotes	Could not be	28e. PLACE O	F INJURY — At hon	e, ferm, atr	et, tectory,	office		26t, LOCATION (Street a	nd Number	or Rural Ro	oute Number
		determined	building,	etc. (Specify)					City or Town, State)			
COMPLET	290. CERTIFIER	IEVING PNYSI	CIAN: To the best of	en benudada da								
₽ B									to the ceuse(s) and men time, date and piece, en-			
႘ႃ						in my opimo	ii, deatii occu	red at the	time, date and piece, en	d due to th	e ceuse(s)	end menner ae stated,
H	29b. SIGNATURE AND TITLE	OF CERTIFIER	1				29c. LIC	ENSE NUM	BER	29d. DAT	E SIGNED	Month, Day, Year)
2		ALLINO	1 1 12 14	UC 7							417	19
	20 NAME AND ADDRESS OF	DEDOON		OF OF FEET	-			_				
	30. NAME AND ADDRESS OF		O COMPLETED CAUS				*1					
	Dr. A. Aus	tin Pe	o completed caus arre, Jr	., M.D.,	300 1		Vinth	Stre	et, Freder	ick,	Md.	21701
		tin Pe	arre, Jr		300 1		Vinth	Stre	et, Freder	ick,	Md.	21701



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e attending physician and completely filled in by the funeral director, page 5 should be detached for use as tt		ury, or other traumatic event, the medical examiner must be notified at once
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	ATE OF DEAT	ГН	REG. NO.	30		
	1. DECEDENT'S NAME (First, Middle, Last)	1.2				2. DATE OF DEATH FO	b 6 1995	3. TIME OF DEATH	
	Joseph A	indrew Whis	sner			MONTH DA	1908AR	6:30 P. W	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	UNDER 1 YEAR IF UNDER	24 HRS.	7. DATE OF BIRTH		THPLACE (State or Foreign	
	218-40-4043	1 M 2 □ F 86	O YRS.	NTHS DAYS HOURS	MIN.			Maryland	
DIRECTOR	90. FACILITY NAME (If not institution, give street and number) Homewood Retirement Center 9b. CITY, TOWN OR LOCATION OF DEATH Frederick 9c. COUNTY OF O								
EC	RESIDENCE OF DECEDENT 106. STATE 106. COUNTY	,	10c, CITY, T	OWN OR LOCATION				10d, INSIDE CITY	
	0	ederick		Frederi	ck			LIMITS?	
FUNERAL	16 College Av	renue		101. ZIP COO	170]	L		S . A .	
В	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR (2 X NO	13. WAS DECENDENT OF H yes, specify Cube	n, Mexica	IIC ORIGIN? (Specify Yes n, Puerto Ricen, etc.)	Ble	CE — American Indian, ck, White, etc.	
ED	15. DECEDENT'S EDUC (Specify only highest grade	CATION	16a. DECEDENT'S US	UAL OCCUPATION		16b. KIND OF BUS	INESS/INDUSTRY		
COMPLETED	Elementery/Secondary (0-12)	College (1-4 or 5+) College	Superir Mails	done during most of working the ndent	of	U.S.	Postal	Service	
O	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden 3	Surnama)		
BEC		Whisner		Ma	arge	aret Ther	esa Le		
2	Mrs. Edith W. F	oland	332 We	est Colle	or Rural F	Poute Number, City or Town	Freder	ick, Ma.	
	20e. METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Remo	ovel from State	b. PLACE AND DATE OF C	DISPOSITION (Name of Cometer)	y 2/	10/95 Fr	ATION — City or	Town, State k, Md.	
	21. SIGNATURE OF PUNETRAL SERVICE LIC	Resige	_	22. NAME AND ADDRES	SS OF FAI	DUTY P	Λ Fran	eral Home	
	Robert W.	Keeney #M		106 E. C	hur	ch St., F	rederi		
	23. PART I. Enter the diseases, or c shock, or heart failure. I	omplications that cause	d the deeth. Do not	anter tha moda of dyi	ng, sucl	n as cardiac or raspir	atory arrest,	Approximata Interval Between	
ı	IMMEDIATE CAUSE (Final		13 145					Onset and Death	
	disease or condition resulting in death)	· Cond	menjerin	to An	-	~			
_		DUE TO (OR AS	A CONSEQUENCE OF):					7%	
CERTIFICATION	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF):	4.				? 2 Hours	
CAI	cause. Enter UNDERLYING CAUSE (Disease or injury	fre	when the	Fremen	eny	ahain		> 20 jenns	
	that initiated events	DUE TO (OR AS	A CONSEQUENCE OF):						
Ä	resulting in death) LAST								
	PART ii. Other aignificant conditions	s contributing to death	but not resulting in t	he undarlying cause g	jiven in	Part I. 24a. WAS AN A	AUTOPSY 24	b. WERE AUTOPSY FINDINGS	
DICAL	PERFORMED? PERFORMED? AMILBUE PRIOR TO COMPLETION OF CAUSE OF DEATHS								
	Free	monty.			-		SCHO	OF DEATH?	
PHYSICIAN: ME	DID TOBACCO USE CONTR	RIBUTE TO CAUSE (OF DEATH YES		ERTAIN	<u> </u>			
Χ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (
Si l	1 TES 2 NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Out		THER: Nursing Home 5 - Re	sidence	6 Other (Specify)			
ξĮ	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME O	F 28c. INJURY AT		28d. DESCRIBE HOW IN	JURY OCCURED		
BY	1 Natural 5 Pending 2 Accident Investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		M 1 YES 2	NO.			- 1	
	3 Suicide 6 Could not be determined	26e. PLACE OF INJURY building, etc. (Spe	Y — At home, ferm, street cify)	et, factory, office		261. LOCATION (Street et City or Town, State)	nd Number or Rural	Route Number,	
9	29e. CERTIFIER	Class. To the board of the							
COMPLETED	(Check only one) MEDICAL EXAMINER	CIAN: To the best of my known: R: On the basis of examination	on and/or investigation, is	t fhe time, date end piece, n my opinion, death occur	end due	fo fhe cause(e) end menr time, date end place, end	er ee stated. I due to the ceuse	(e) end menner se stated.	
띪	29b. SIGNATURE AND TITLE OF CERTIFIER	more	2 -		NSE NUM	BER 8191		D (Month, Day, Year)	
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type Prin						
	Dr. Arthur G.	Manalo M.	D. 187 T		nso	n Dr., Fr	ederic	k, Md.	
	FEB 0 8 1995	32. HEGISTRAN'S SIGN	WATURE PORCELLE						
	FED U U 1000	10							



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a found after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

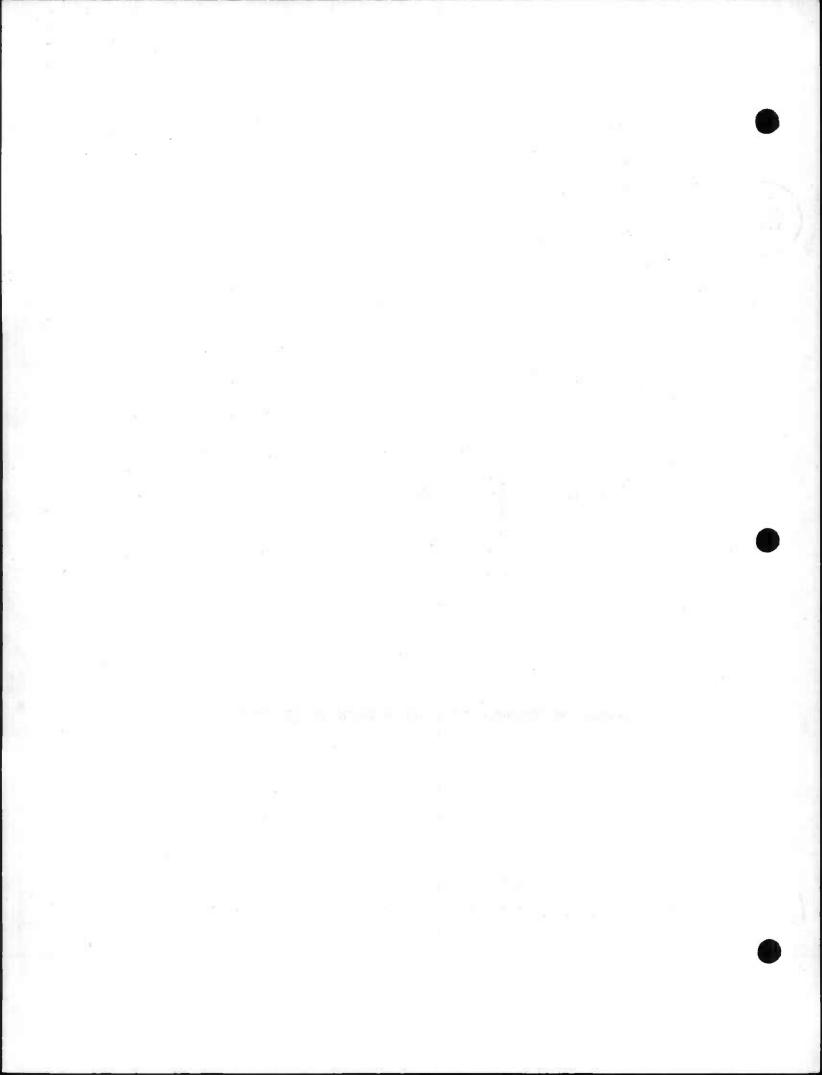
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

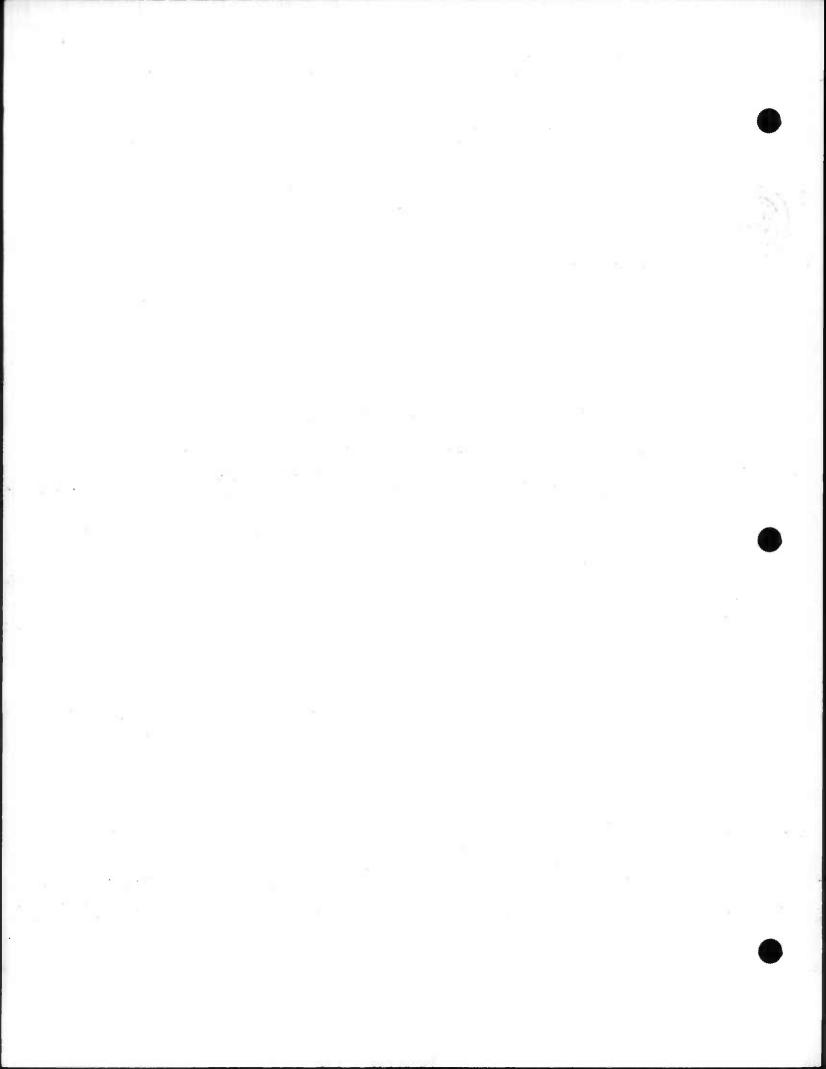
	REGISTRAR		CERTIF	ICATE O	F DEATH	REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)	•				2. DATE OF DEATH		3. TIME OF DE	ATH	
	Clifford White					1 3	ay 1 C	95 4:10	Δм	
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BIRTH		8 BIRTHPI ACE (State or	Formion	
	577-01-3975	¥XM2□F	75 YRS.	MONTHS DAYS		July 19	1919 W	Vashington,	D.C.	
	9a. FACILITY NAME (If not institution, give s	treat and number		Oh CITY TOW	N OR LOCATION OF D			TY OF DEATH		
œ				· ·		EATH				
2	Brook Grove Nursi	ng nome		Olney	<u> </u>		Montgomery			
EC	10a. STATE 10b. COUNTY	1	10c, CIT	Y, TOWN OR LO	CATION			104 INSIDE CO	rv	
E I	Maryland Mont	gomery		eaton				10d. INSIDE CIT	7	
7	10e. STREET AND NUMBER	gomery	1 111		101. ZIP CODE		T	1 X YES 2		
FUNERAL DIRECTOR	12716 Feldon St.				20906			EN OF WHAT COUNTRY?		
빌	12/10 FEIGOII St.							S.A.		
3	1 Never Marriad 2 Married	12. WAS DECEDENT ET		If yes,	specify Cuban, Maxic	NIC ORIGIN? (Specify Yea an, Puerto Rican, stc.)	or No-	 RACE — American Inc Black, White, etc. 	dlen,	
Β¥	3 🕅 Widowed 4 🗌 Divorced	IF YES, GIVE WAR	OR DATES	1 🗆 Y	ES 2 NO Specif			Specify: white		
	15. DECEDENT'S EDU	CATION	16a. DECEDENT'S				1			
COMPLETED	(Specify only highest grade	completed)	(Give kind of	work done during se retired.)	most of working	16b. KIND OF BU	SINESS/INDU	ISTRY		
7	Elementary/Secondary (0-12)	College (1-4 or 5+)	Basketb			organi	zed s	mrts		
Ž	17. FATHER'S NAME (First, Middle, Last)			022				porte		
	Edward White					MME (First, Middle, Maiden Gutridge	Sumame)			
BE										
9	19a. INFORMANT'S NAME (Type/Print) Adele Stein		19b. MAILING	ADDRESS (Street	t and Number or Rural	Route Number, City or Tow				
			12/10	reladi	1 St., WIR	eaton, MD	20906)		
	20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☆ Cremation 3 ☐ Ram	oval from Stata	20b. PLACE AND DATE	OF DISPOSITION	Neme of	DATE 20c. LO	CATION - C	Ify or Town, State		
	4 Donation 5 Other (Specify)	16	Metropolit	an Crer	natory Fel	o.3,1995 A	lexand	dria,VA		
	21. SIGNATURE OF PUNETIAL BETTVICE LIC	ENTEL	2	22. NAME	AND ADDRESS OF FA	voility Takoma	Funer	cal Home, 1	Inc.	
	The same of	47700	and	254 (Carroll St	t. NW Wash:	ington	n, D.C. 200	12	
-	23. PART I. Enter the diseases, or o	comblications that ca	used the death. Do	not enter the r	node of duing eur	th as cardiac or read	Iretoni orre	st, Approxir		
l	shock, or heart failure.	List only one cause	on each line.			ar acrosso of reop	inatory arre	Interval	Between	
İ	IMMEDIATE CAUSE (Final disease or condition	A	Adam Danie						nd Desth	
- 1	reculting in desth)		AS A CONSEQUENCE O					10 da	ays	
_		Dyspha		r):						
6	Sequentielly list conditions,	0	AS A CONSEQUENCE O	EV:						
A	If sny, leeding to immediate cause. Enter UNDERLYING			e Dementia						
CERTIFICATION	CAUSE (Diseese or Injury	C	AS A CONSEQUENCE O							
E	that initiated events resulting in deeth) LAST									
핑		d								
7	PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTO									
EDICAL							PERFORMED?		R TO CAUSE	
								OF DEATH?	100	
. W	DID TOBACCO USE	CONTRIBUTE 1	CAUSE OF	DEATH	YES I NO			TES 2	NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	CONTRIBUTE	O CAUGE OF		PLACE OF DEATH (C/	LALE				
S	EXAMINER? 1 YES 2 NO	HOSPITAL:	(Outpetlant 3 DOA	OTHER:		11 12 2				
ž	27. MANNER OF DEATH	28a. DATE OF INJ			ome 5 Residence	26d. DESCRIBE HOW I	N II IDV OCCI	IBED		
	1 Netural 5 Pending	(Month, Day,)		URY	YES 2 NO	200. DESCRIBE NOW I	NJORY OCC	THED		
B	2 Accident Investigation	28s. PLACE OF IN	JURY — At home, ferm,			204 1 00471041 (01-14	and March and	D-10-11		
8	3 Suicide 6 Could not be 4 Homicide determined	building, atc.	(Specify)	orreet, factory, or	1100	28f. LOCATION (Street a City or Town, State)	and Number o	r Hurai Houte Number,		
COMPLETED	29a. CERTIFIER									
릴	(Check only									
δ I	2 MEDICAL EXAMINE	R: On the beals of exem	nation and/or investigation	on, in my opinion	, death occured at the	time, data and place, an	d due to the	cause(a) and manner as	stated,	
BE (296. SIGNATURE AND TITLE OF CERTIFIES	1			29c. LICENSE NU	MBER	29d. DATE	SIGNED (Month, Day, Year	r)	
	< 120 Decue	MI)			D33700		•	1-31-95		
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE O	F DEATH (ITEM 27) (Type	, Print)	1			- 51)5		
	Ted E. Howe, M. D.				Sandy Spr	ing, MD 2	0860			
	31. DATE FILED (Month, Day, Year)				25 061				-	
	FEB 02 199	15 Julia De	SIGNATURE RENDALL							
									16 Pay 1/90	



BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician	led in by the funeral director, page 5 should be detached for use as the burial-train, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-train be filled within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF	MARYLAND / DEPARTMENT	OF HEALTH A	ND MENTAL	HYGIENE
	CERTIFICATE	OF DEATH	4	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT (OF HEALTH AND	MENTAL HYGI			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEAT MONTH	H DAY	YEAR	3. TIME OF DEATH
	GERTRUDE S. 4. SOCIAL SECURITY NUMBER 5.		ALTER			JANUARY	30,199	_	3:30 A M
	079-03-2359	□ M 2 🖔 F	in yrs. lest birthday)	MONTHS 6	/EAR IF UNDER 24 HRS. MAYS HOURS MIN.	7. DATE OF BIFTI- (Month, Day, Yes MAY 15,1	ir)	8. BIRTHI Country NEW	PLACE (State or Foreign YORK
OR	9a. FACILITY NAME (If not institution, give street 2303 DENNIS AVENT				DWN OR LOCATION OF D LVER SPRING	EATH		GOMEI	
ECT	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c CI1	Y, TOWN OR	LOCATION				
FUNERAL DIRECTOR	MD. MONTGO	OMERY	1		SPRING				10d. INSIDE CITY LIMITS? 1 YES 2 X NO
HA	2303 DENNIS AVENUE	ar			10f. ZIP CODE 20910)	100		HAT COUNTRY?
N D		2. WAS DECEDENT EVER IN	U.S. ARMED	13. WA	S DECENDENT OF HISPA			S.A.	- American Indian,
BY	1 Never Married 2 Merried 3 1 Wildowed 4 Divorced	FORCES? 1 YES		If y	es, specify Cuban, Maxico YES 2 NO Specifi)		White, atc.
TEO	15. DECEDENT'S EDUCATI (Specify only highest grade con	ION npleted)	16a, DECEDENT'S (Give kind of	work done dun	JPATION Ing most of working	16b. KIND OF	BUSINESS/IND	USTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	HOUSEWI			OWN 1	IOME		
MO	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Ma			
ш	JOHN M. SOMMER				MATILD				
TO B	19a. INFORMANT'S NAME (Type/Print) JANE W. GASTILO		19b. MAILING 2303 I	ADDRESS (S	AVE. SILV	Route Number, City or	Rown, State, Zip	Code)	0
	28p. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State 20b.	PLACE AND DATE	OF DISPOSITI	ON (Name of	DATE 20c	LOCATION — C	aty or Tow	
j	21. SIGNATURE OF FUNERAL SERVICE LIGHTS		· OBLVB.		ME AND ADDRESS OF FA EPH GAWLER		JFFALO,	NY.	
	> fund/ kll		M10957	513	EPH GAWLER O WI. AVE.	'S SONS,	INC	N D	0 20016
NOIL	23. PARTI. Enter the diseases, or com abock, or heart failure. List immediate CAUSE (Fine) disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate	OUE TO (DR AS A	CONSEDUENCE O	F):	e mode of dying, auc	n se cerdiac of n	sepiratory arre	pat,	Approximata interval Between Onset and Death
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d	DUE TO (DR AS A	CONSEDUENCE O	F):					
A I	PART II. Other significent conditions co	ontributing to deeth bu	It not reauiting	in the unde	riying cause given in	PER	AN AUTOPSY FORMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
PHYSICIAN: MEDIC						1 _ YE	S 2 🔯 ND	'	OF DEATH?
Z	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	F DEATH YE	S 🗆 NO	UNCERTAIL	N D			
<u>S</u>	25. WAS CASE REFERRED TO MEDICAL EXAMINER? The second of t	OSPITAL:	28. PLACE OF DEA						
14S	1 YES 2 NO 1 C	Inpatient 2 ER/Output 28a. DATE OF INJURY		4 Nursing	Home S Residence				
BY PI	1 X Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)		M 1	c. INJURY AT WORK?	28d. DESCRIBE HO	W INJURY OCCI	URED	
	3 Suicide 6 Could not be datarmined	28a. PLACE OF INJURY building, etc. (Special	— At home, farm, :	street, factory,	offica	28f. LOCATION (Str. City or Town, St		or Rural Ro	ute Number,
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN ONE) 2 MEDICAL EXAMINER: D	i: To the best of my knowle							and manner as stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	2//	A e	0	29c, LICENSE NUN	4BER 2703			Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO A	MPLETED CAUSE OF DEA	TH (ITEM 27) (Type,	Print)	40-2	-103	Jan		,,1333
		10301 GEORG		#104 5	SILVER SPRI	NG, MD	20902	2	
	FEB 02 1995	32. REGISTRAR'S SIGNA	Lion-Randal						
		- ()	-						



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OF VITAL RECORDS, P.O. BOX 68760	
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	examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
1	e funeral director, page 5 should be detached for use as the burial-transit per II.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permorp be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
	death. Page 6 may be retained by the hospital or attending physician.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician.

	1 - STATE REGISTRAR	SIAIE UF W	TARYLAND /		ICATE				VIEN IA	REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle,	i, Last)		,					2. DAT	E OF OEATH	v		3. TIME OF DEATH
	Sadie	m.		V	VUL	cers			Ja	nuary	31 1	1993	0852 "
	4. SOCIAL SECURITY NUMBER	5. SEX 1 ☐ M 2 🔯 F	6. AGE (In yrs. last	t birthday) YRS.	MONTHS		IF UNDER	24 HRS.	(Mon	e OF BIRTH J		Country	,
×	218-20-4144 9s. FACILITY NAME (If not institution	- 11	73	THO.	as CITY	TOWN OR	CATIC	211 OF DE		. 2, 19		MARY	
R	PENINSULA REG		AI CENTE	ים ^י		ALISE			Alh			ICOM	
5	RESIDENCE OF DECEDER	NT	AL CENTE									LUUM	
DIRECTOR		COUNTY			Y, TOWN O							16	10d. INSIDE CITY LIMITS?
	100. STREET AND NUMBER	MEKSEI		PK	INCES		NNE ZIP CODE	-			10a CITI		1X YES 2 ☐ NO HAT COUNTRY?
FUNERAL	30514 NUTTERS	LANE					2185					USA	nai cooninii
S	11. MARITAL STATUS		T EVER IN U.S. ARM	WED	13. V	MAS DECEN	NDENT O	F HISPAN	IC ORIG	IN? (Specify Yes		14. RACE	- American Indian,
BY F	1 Never Married 2 Married 3 N Widowed 4 Divorced	IF YES, GIVE W	YES 2 NO	O		f yes, spec				Rican, atc.)		Specify	White, etc.
	15. DECEDENT		16a. DEC	CEDENT'S	USUAL OC	CUPATION	ч .		16	b. KIND OF BUS	INESS/IND	четру	WHITE
COMPLETED	(Specify only highes Elementary/Secondary (0-12)		(Giv	ve kind of a	work done di se retired.)	luring most	of working	g	"	o. Amo o. Des	(NEGG) IIV	Ug Ini	
WPL	7			IOMEN	MAKER								
CO	17. FATHER'S NAME (First, Middle, Le	nst)								Middle, Maiden			
BE	PAUL TWIGG									RICHARD			
5	19a. INFORMANT'S NAME (Type/Prin	,								nber, City or Town		2180	11
	20e. METHOD OF DISPOSITION		20b. PLACEA	NDDATE	OF DISPOSIT	ITION (Neme		EI,	DALL			City or Tow	
Ì	1 N Burial 2 Cremation 3 4 Donation 5 Other (Specify	y)	PARSON						2/			-	ARYLAND
1	21. SIGNATURE OF PUNERAL SERV	SCE LICENSES	111.		22. N	NAME AND			HLITY	ME, P.			
	Seensu	white	ILLIC							-			1/1 RY,MD21802
	23 PART. Enter the disease shock, or heart fa	s, or complications that	caused the das	ath. Do r	not antar	tha mode	a of dylr	ng, such	as car	rdiac or reapi	retory arr	est,	Approximata
	IMMEDIATE CAUSE (Final	mark conduct only	4				1_						Onset and Daath
	disease or condition resulting in death)	Ca			an	ues							1 hour
_		- July	(OR AS A CONSEQ	UENCE O	F):	2-6	In-						ichn
ō	Sequentially list conditions, if any, lasding to immediate	DUE TO	OR AS A CONSEQU	diffece q	n .	V U	17	7	0				11310-
CAT	cause. Entar UNDERLYING CAUSE (Disease or injury	2. my	to con	As.	٩	dr	fore	ten		,			1,5 h
E	that initiated events	OUE 10	AS A CONSECU	UENCE O	F):	- H	1 1	115	1.	_			1/12/25
CERTIFICATION	Touching it should are	(/ / /	a por		· w	Cu	rolo		my	-			1110/13
CAL	PART II. Other algnificant con	ditions contributing to	daath but not ra	suiting	in tha unc	darlying	cause g	iven in f	Part i.	24s. WAS AN			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
DIC	COPY	1/4	- Hear	- 4						1 - YES 2			COMPLETION OF CAUSE OF DEATH?
MEDI	Cryan	1	7 dise					- > ++				1	1 - YES 2 NO
PHYSICIAN:	DID TOBACCO USE CO			_	TH (Check o	10 1Z	UNC	ERTAIN	1 🗆	L			
SICI	EXAMINER?	HOSPITAL:	ER/Outpatient 3 [OTHER		s □ Re	-Idenes i	- Deb	(P===/h/l)			
ř.	27. MANNER OF DEATH	28a, DATE OF	INJURY	26b. TIM	E OF	28c. INJUR	RY AT	Moenca (er (Specify) SCRIBE HOW IN	JURY OCC	UREO	
ВУ Р	1 Natural 5 Pending 2 Accident Investig		ly, Year)	ING	M	1 YE		NO					
	3 Suicide 6 Could n	building, a	F INJURY — At hom atc. (Specify)	na, farm, e	atraat, tacto	ory, office			28f. LO	CATION (Street a or Town, State)	nd Number	or Rural Ro	oute Number,
13. H	an orestron /												
COMPLETED	>	PHYSICIAN: To the best of											,
8		(AMINER: On the basis of ax	amination and/or in	iveatigatio	n, In my op					e and place, and			
띪	296, SIGNATURE AND TITLE OF CEI	ATTIFIER Down	in In	1		2	29c. LICE	NSE NUMI	BER		29d. DATE	SIGNED	Monty, Day, Year)
2	30. NAME AND ADDRESS OF PERSO	ON WHO COMPLETED CAUS	E OF DEATH (ITEM	27) (Type	. Print)		1)7	1/2	90			/ 5/	/ / -
	ROBERG	ω ,	1)0 a) No.	E		220	5 7	16	GHMI	an	RS	
	31. DATE FILEO (Month, Day, Year) FFR () 3 199	A REGISTRAL	RESIGNATORE	П.		-	5	720	15	BUR	y	ner	12/801
- 1	FFR 0 3 199	J 7/1000 00 00	mater a go or	Variable 1			0						, ,

use as the burial-transit

ysician and completely filled in by the prior to burial, cremation, or removal.

this certificate has been signed by the attending physician with the State Oept, of Health and Mental Hygiene prior to

L OIRECTOR: After the hours after death w

/	STATE	STATE OF I	/ MARYLAND	DEPAR	TMENT	OF H	EALTH	AND	lontgon RT MENTAL HYGIEN	n eg	a to	194059 Jomery
	REGISTRAR		CE	RTIF	CATE	OF	DEAT	ТН	REG. NO.		U	
		PSON		WARR	EN				2. DATE OF DEATH MONTH JANUARY 19	,199	5 YEAR	3. TIME OF DEATH 2:55 am
	4. SOCIAL SECURITY NUMBER 578.62.7665	5. SEX 1 M 2 F	6. AGE (In yrs. lest		IF UNDER 1	YEAR DAYS	IF UNDER HOURS	MIN	7. DATE OF BIRTH (Month, Day, Year) MARCH 31,1	901	Count	HPLACE (State or Foreign ry) YLAND
	9a. FACILITY NAME (If not institution, give st FERNWOOD HOUSE RESIDENCE OF DECEDENT	reet and number)				HES	DA			9c. COU	NTGO	DEATH
	100. STATE 100. COUNTY	GOMERY			r, town of ETHES		TION					10d. INSIDE CITY LIMITS? 1 YES 2 NO
	6530 DEMOCRACY BI	LVD					2081			10g. CIT	U.S	what country?
	11. MARITAL STATUS 1 Never Married 2 Married WWW Widowed 4 Divorced		T EVER IN U.S. ARM YES 2 TAN AR OR DATES		10	yes, sp	ENDENT O	F HISPAN n, Mexica Specify	NC ORIGIN? (Specify Yearn, Puarto Rican, etc.)	or No—	14. RACI	E — American Indian, k, White, atc.

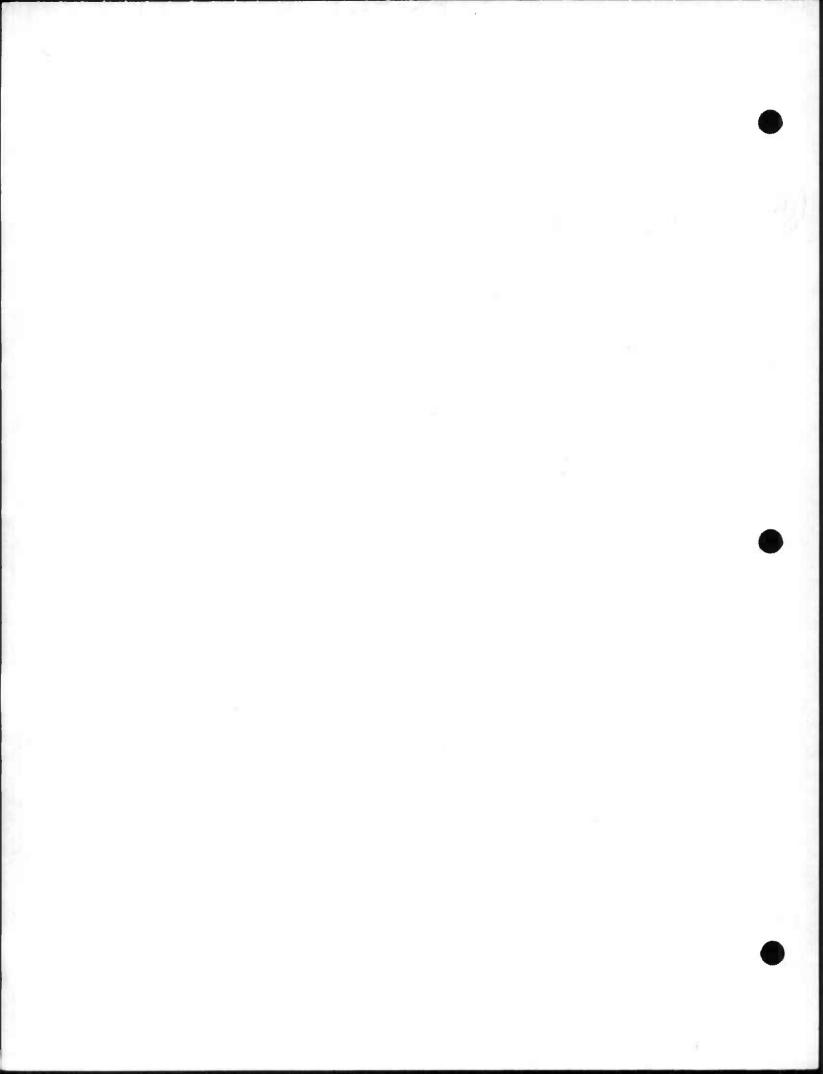
BY FUNERAL DIRECTOR COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spe College (1-4 or 5+) HOMEMAKER OWN HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) JOSEPH HAMPSON, BE JR. ADA GRACE MOBRAY notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 JAMES ROSS WARREN 117 KIOWA AVE. #6 LOS ANGELES, CA. 90049 must be 20s. METHOD OF OISPOSITION

1 X Burlet 2 Cremation 3 Removal from Stale
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State LOUDON PARK CEMETERY 1/26 BALTIMORE, MD. medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLER'S SONS eak etero 5130 WISCONSIN AVE., NW WASH., D.C. 20016 23. PARTA. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart feliure. List only one cause on each line. Interval Between Onaet and Death **IMMEDIATE CAUSE (Final** the Fail diseese or condition_ ardiae traumatic event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF) ayterioseleron CERTIFICATION Sequentially list conditions. OUE TO (OR AS A CONSEQUENCE OF): If any, laeding to immediate Coronary altery distant.

DUE TO (OR AS A CONSEQUENCE OF): e. Enter UNDERLYING CAUSE (Disease or Injury or other that initiated evants resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 23 shows any Vascular 1 YES 2 1-10 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item OTHER:
4 Nursing Home 5 Realdence 8 Other (Specify) 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 6 27. MANNER OF DEATH 28a. OATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCUREO Item 28 Is marked, 1 Natural INJURY 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 8 Could not be COMPLETED 4 Homicide 29a. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF TO THE FUNERAL OF THE MINING TO THE MINING THE 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 3131 lbut 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) LORETO S. ALBIOL, M.D. 8218 WISCONSIN AVE. #105 BETHESDA, MD. 20814-3107

31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Julia Davelson Revolate





hours after death. Page 6 may be retained by the hospital or attending physician BALTIMORE, MARYLAND 21215-0020

een signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for i of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a frours after death. Page 6 may be retained by the hors TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CERTIFICATION

PHYSICIAN: MEDICAL

BY

COMPLETED

BE

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

use as the

DIRECTOR

FUNERAL

BY

COMPLETED

BE 2

Imended	74-	16	1-24	195		m	RT		Mo	nt	20	me	r4	Ctu
- STATE REGISTRAR		STATE OF M	AHTLAN	CERTIF	ICA		TEALTH DEA			HYGIEŅ REG. NO	F		4	8
1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF	DEATH			3. TIME	OF DEATH
MARY		SCOTT			WE	EENIN	ΙK		MONTH.		AY C	YEAR Q.5	12	•45 D*
4. SOCIAL SECURITY NUM	BER	5. SEX	8. AGE (In y	rs. lest birthday)	JF UM	DER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF	BIRTH 1	050	8. BIRTH	PLACE (S	State or Foreign
229-64-3130		1 🗆 M 2 🗍 F	44	YRS.	MONTH	S DAYS	HOURS	MIN.	Decem	ber		Virg	**	а
90. FACILITY NAME (If not in	stitution, give e	treet and number)			9b. C	ITY, TOWN	OR LOCATI	ON OF DE				INTY OF D		
8515 FREYMAN DRIVE					SI	LVE	SP-	RIN	chev	90	MO	NTGC	MER	₹Y
RESIDENCE OF DEC									-	36				
10a. STATE	10b. COUNTY			10c. CIT	ry, TOW	H OR LOCA	TION							SIDE CITY
Maryland	Mo	ontgomery			Che	evy C	hase					- 1		ES 2 NO
10e. STREET AND NUMBER							. ZIP COD	E			10g. CIT	IZEN OF W	WHAT CO	UNTRY?
8515 Freyman Drive 20815 U.S.A.														
11. MARITAL STATUS		12. WAS DECEDENT FORCES? 1	EVER IN U.	S. ARMED	1				VIC ORIGIN? (S			14. RACE	- Amer	ricen Indian,
1 Never Married 2		IF YES, GIVE W					2 NO		n, Puerto Rica	n, atc.)		Specia	k, White,	etc.
3 🔀 Widowed 4 🗌 Divo	rced						Carl.	,					7hite	
15. DEC (Specify onl)	EDENT'S EDUC y highest grade	CATION completed)	16	n. DECEDENT'S	IT'S USUAL OCCUPATION of work done during most of working					HILLS				
Elementary/Secondary (0	1-12)	College (1-4 or 5+)		life. Do NOT u	se retired	d.)								
12			l _R	eceptio	onis	st			Ra	nkin	~			
17. FATHER'S NAME (First, M	iddle, Last)						18, MOT	HER'S NA	ME (First, Midd					
Thomas K. S	cott							elia			ollis	3		
19a. INFORMANT'S NAME (ype/Print)		-	19b. MAILING	ADDRE	ESS (Street e	nd Number	or Rural I	Route Number,					
Hollis Stau	ber			8614 (Bethe				208	317
20a. METHOD OF DISPOSIT 1 □ Burlel 2 □ Crematic 4 □ Donetion 5 □ Other	n 3 🗆 Ramo	oval from State	cemeter	ACE AND DATE y, crematory or o	ther plac	ce)			DATE	20c. LO	CATION —	City or To	wn, State	
21. SIGNATURE OF FUNERA		7	IMet:	ropoli					1/25/9	5 Ale	exand	iria,	Virg	inia
an ordinary of the service of the se						2. NAME A		SS OF FAI	CILITY					_
Mark	1	1/1/1	Well.		1	במונכ.	ro J.	CO1	lins	runei	ral F	iome,	Inc	
- Levou		0000				100 01	itvei	SIL	Blvd	W .	Sil.	Spr.	MD	20901

Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events

resulting in death) LAST

IMMEDIATE CAUSE (Finel

disease or condition resulting in death)

. CARDIAC ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. DIABETES MELLITUS, CHRONIC RENAL INSUFFICIENCY

24a, WAS AN AUTOPSY 24h. WERE ALITOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO 1 _ YES 2 _ NO

Approximeta

Onset and Death

DID TOBACCO USE CONTRIBUTE 1	O CAUSE OF DEATH	YES 🗌 NO 🗆	UNCERTAIN [
WHE CASE DEPENDED TO MEDICAL	22 21 122 22		

EXAMINER? OTHER:

1X YES 2 □ NO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 27. MANNER OF DEATH

ng Home X Maeldence 8 - Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED

Pending 1)() Natural 2 Accident 3 Sulcide Could not be

4 Homicide

1 YES 2 NO 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify)

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest,

281. LOCATION (Street end Number or Rural Route Number, City or Town, State)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date end place, and due to the cause(e) and manner ee stated,

2 💢 MEDICAL EXAMINER. On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(e) and manner ee stated.

296. SIONATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER

29d. DATE SIONED (Month, Day, Year) JAN 24, 1995

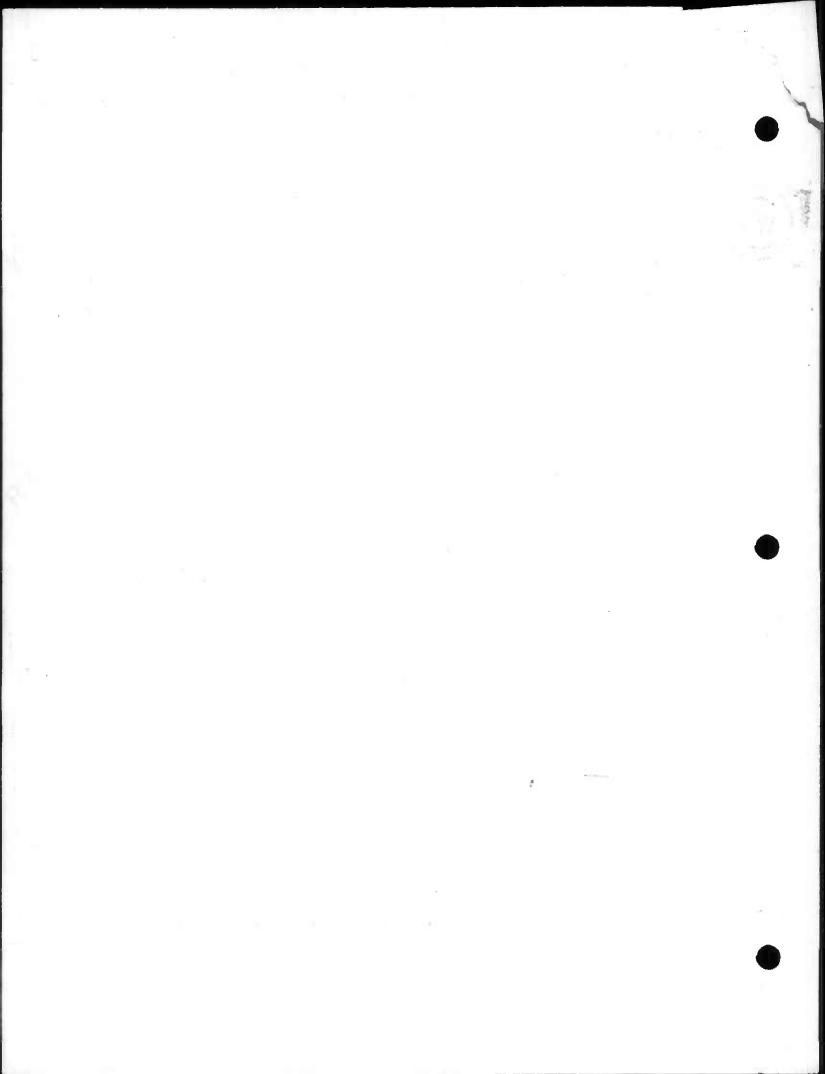
tewo 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

shock, or heart fellure. List only one ceuse on each line.

Penn Street, Baltimore, Maryland 21201 111

32. REGISTRANS SIGNATURE

DHMH-18 Rev 1/89



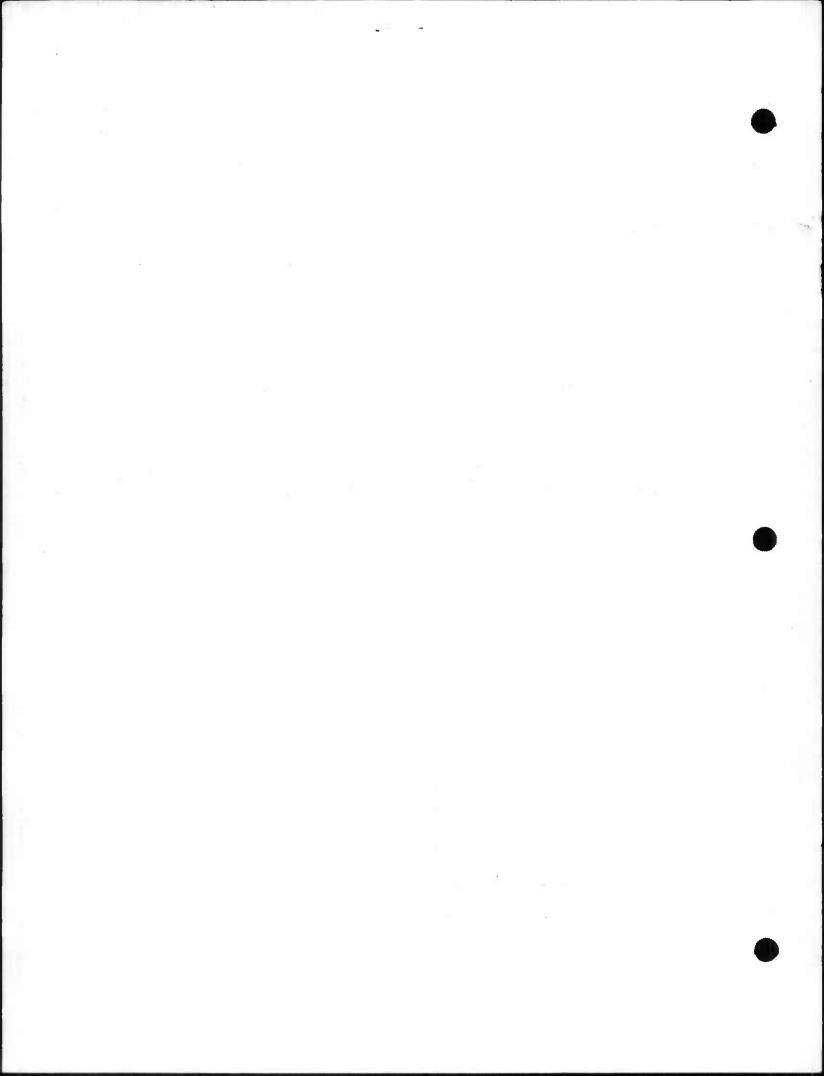
FOR

	1 - STATE REGISTRAR	SINIE OF	CE		ICATI	OF	DEAT	TH	MENIAL	REG. NO.	Ŀ		
	1. DECEDENT'S NAME (First, Middle, Les								MONTH	OF DEATH	IA.	YEAR	3. TIME OF DEATH
		YODER							FEBR	UARY 2	19	95	9:05 Am
	4. SOCIAL SECURITY NUMBER N/A	5. SEX	6. AGE (In yrs. last	YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	(Month	OF BIRTH , Day, Year)		Countr	
	9a. FACILITY NAME (If not institution, give		0	THS.	At 0177					21,			RYLAND
œ	263 YODER ROAD	stront and number)			96. CITY		LAND		ATH		100	ITY OF D	
5	RESIDENCE OF DECEDENT				<u> </u>	OTH	LILLIND				GAR	KEII	
DIRECTOR	10a. STATE 10b. COUN			10c. CIT	Y, TOWN		ION						10d. INSIDE CITY LIMITS?
	MARYLAND 100. STREET AND NUMBER	GARRETT			OAKL								1 TES 2 X NO
FUNERAL	263 YODER ROAD					101	2155	_			,	ZEN OF W	VHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES?	T EVER IN U.S. ARI			If yes, spe		n, Maxicar	n, Puerto A	? (Specify Yas licen, atc.)	or No	14. RACE Black Speci	E American Indian, c, White, atc.
	15. DECEDENT'S ED		18a. DEC	CEDENT'S	USUAL O	CCUPATIO	ON .		16b	KIND OF BUS	INFSS/IND	USTRY	" WHITE
COMPLETED	(Specify only highest gra	de completed) College (1-4 or 5	+) (Gir	ve kind of Do NOT u	work done sa retired.)	during mo	st of working	ng .					
MPL	2		S	TUDE	NT					SCHOOL			
00	17. FATHER'S NAME (First, Middle, Last) JOHN DANIEL YODE	D			_					liddle, Malden			
BE	19a. INFORMANT'S NAME (Type/Print)	K .								CHROCK			
2	JOHN DANIEL YODE	R			YODE					ND, MI		,	
	20a. METHOD OF DISPOSITION 1 № Buriel 2 □ Cremation 3 □ Ra	moval from State	20b. PLACE A	NODATE	OF DISPOS	ITION (Na	me of		DATE	20c. LO	CATION —	City or To	wn, Stata
	4 Donetion 5 Other (Specify)		SLAI	BAUGI					2/5	OAK	LAND	, MA	RYLAND
	21. SIGNATURE OF FUNERAL SERVICE	Duce	/ M001	67			FUN				O. B		43 D 21550
	23. PART I. Enter the diseases, or shock, or heart failure	r complications the	it caused the der	ath. Do i	not entar	tha mo-	da of dyl	ng, suct	n as card	iac or respi	ratory arr	est,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition		A A TOTAL STREET		1		1 0		0				Onset and Death
	resulting in death)	a. DUE TO	OR AS A CONSEC	() (CYI	~/	no	an	4				600-
_	_	DOE 10	(ON AS A CONSEC	OENCE O	r):								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSEO	UENCE O	F):								
S	CAUSE (Disease or Injury	С											
E	that initiated events	DUE TO	(OR AS A CONSEO	UENCE O	F):								
CER		d											-
	PART II. Other algolificant condition	ona contributing to	death but not re	suiting	In the ur	derlying	cause ç	iven in I	Part I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
PHYSICIAN: MEDICAL									_	1 TES 2			COMPLETION OF CAUSE OF DEATH?
ME									_				1 YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL	1											
Sic	EXAMINER?	HOSPITAL:	ER/Outpatient 3		OTHER	₹:	A		ock only one				
H	27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIM	E OF	28c. INJ	URY AT	aldence	8 Other	(Specify)	NJURY OCC	URED	
ВУР	1 X Natural 5 Pending Investigation	(Month, E	Pay, Year)	INJ	M		RK? 'ES 2	NO					
- 4	2 Accident Investigation 3 Suicide 6 Could not b.	26a. PLACE C	OF INJURY — At hor atc. (Specify)	na, farm,	straet, fact	ory, office			26f, LOCA	TION (Street a	nd Number	or Rural R	loute Number,
	4 Homicide determined		are: (Opocny)						City o	or Town, State)			
COMPLETED	29a. CERTIFIER 1 X CERTIFYING PHY	SICIAN To the best of	my knowledge, das	ith occurr	ed at the t	lme, date	end place,	and due	to the caus	ee(a) and man	ner aa atat	ed,	
S S	one) 2 MEDICAL EXAMII	NER: On the beals of a	xamination end/or in	rvestigatio	en, in my o	plnion, d	eath occur	ed at the	time, deta	and place, en	d due to th	e cause(a) and manner as stated.
ш	29b. SIGNATURE AND TITLE OF CERTIFI	ER A	10 -	,	5		29c. LICE	NSE NUM	IBER		29d, DATE	SIGNED	(Month, Day, Year)
TO B	JERRY ADAMS, M.		Van	~/			D39	811			▶ F	EB.	3, 1995
	30. NAME AND ADDRESS OF PERSON W					T A 377	215	E C					
	311 N. FOURTH S 31. DATE FILED (Month, Day, Year)		OAKLA		MAKY	LAND	215	5 0					
- 1	EED - 9 100E	A. HEGISTRO	S SIGNATURE	3									

BALTIMORE, MARYLAND 21215-0020 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the fund be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

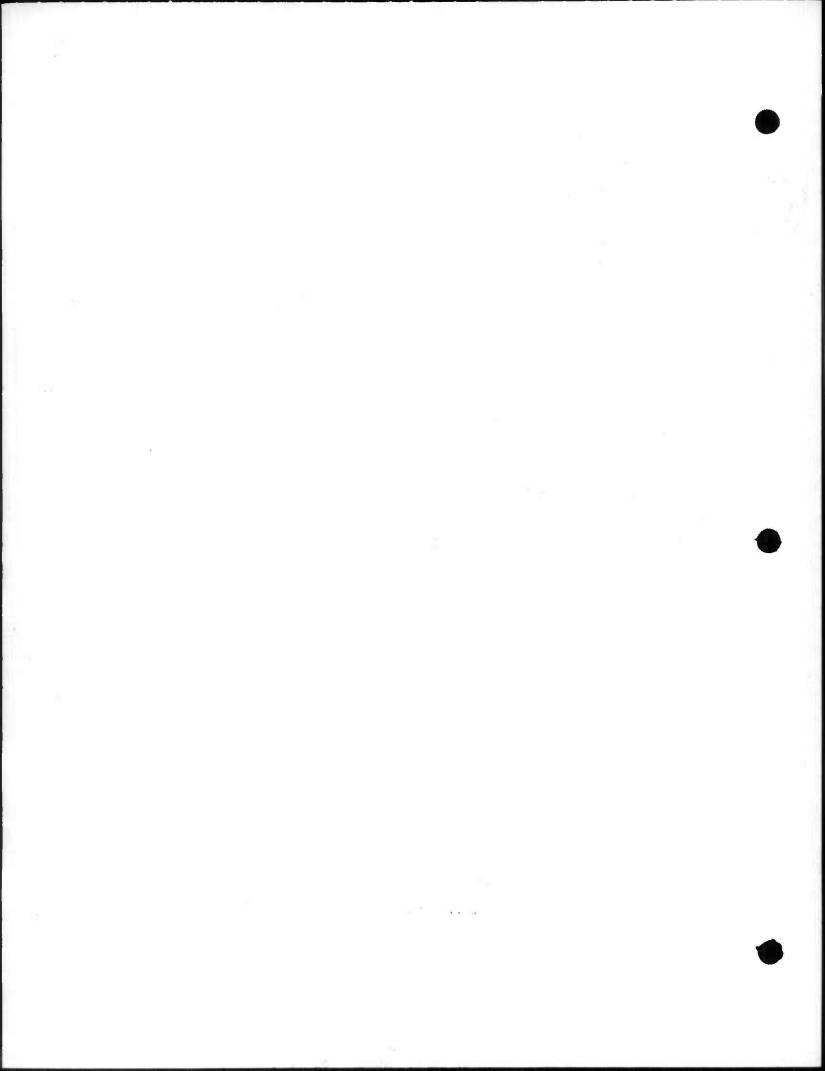
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,



BALTIMORE, MARYLAND 21215-0020	A hours after death. Page 6 may be retained by the hospital or attending physician.	filled in by the funeral director, page 5 should be detached for use as the burial-transit on removal.	re medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at ones.

	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI	MENT OF H	EALTH AND DEATH	MENTA	HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Lest)		SIN	4		2. DATE	OF OEATH		EAR	3. TIME OF OEA	тн 🕈 м
	4. SOCIAL SECURITY NUMBER 072-28-9254 99. FACILITY NAME (If not institution, give str	1 🛣 M 2 🗆 F 91	YAS.	F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	June	of BIRTH th, Day, Year) 28, 1	903	New New	York	oreign
TOR	Suburban Hospital			Bethes	da	EATH		Monto			
DIRECTOR		gomery		OWN OR LOCAT	ION	_			1	IOd. INSIDE CIT LIMITS?	
NERAL	6111 Montrose Roa				20852			USA	OF WH	IAT COUNTRY?	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried 3 Divorced	12. WAS OECEDENT EVER IN U FORCES? 1 ☐ YES IF YES, GIVE WAR OR DAT	2 NO	If yes, spe	ENDENT OF HISPA! ecity Cuben, Mexica 2 NO Specif	n, Puerlo	N? (Specify Yes Rican, etc.)	s or No 14	Black,	- American Indi White, etc. White	len,
COMPLETED	15. OECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of work life. Do NOT use n	done during mos stired.)	N st of working		, KIND OF BU			- 11	
COMP	8 17. FATHER'S NAME (First, Middle, Last)		Store O	wner	16. MOTHER'S NA	ME (First,			en s	s wear	
TO BE	David Zink 190. INFORMANT'S NAME (Type/Print)				Rose G	Route Num	ber, City or Tow				
	David Zink 20e. METHOD OF DISPOSITION 1 Deurle 2 Commented 3 Remo		17 SCO PLACE AND DATE OF E Pery, crematory or other	DISPOSITION (Nat	utumn Co	DAT		cation - cin			
	4 Donation 5 Other (Specify)	/ Kin	g Solomo	Memor 22. NAME AN Edwar	ial Park d Sagel Rockvill	cun Fune	ral Di	rectio	on		
	23. PART I. Enter the diseasea, or co shock, or heart failure. L			enter tha mod	de of dying, suc	h as car	diac or reap	ratory arrest	t,	Approxim interval B	ate
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	ASPIR	ATION) Pr	Homo	NI	A			Onset sno	Death Out
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF): KIN OWN CONSEQUENCE OF):	Pr,	ns in mary	Br	uan	guri			-
MEDICAL (PART II. Other algnificant conditions	contributing to death but	t not reaulting in t	ha underlying	cause given in	Part I.	24a. WAS AN PERFOR 1 YES 2	MED?	O O	VERE AUTOPSY F WAILABLE PRIOR COMPLETION OF (OF DEATH?	CAUSE
AN: M	DID TOBACCO USE CONTR		DEATH YES		UNCERTAIN	N 🗆			1	□ YES 2 □	No
PHYSICIAN:	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 1 Inpatient 2 ER/Outpati	_ 0	THER:	5 🗆 Residence	6 🗆 Othe	er (Specify)				
ВУ РН	27. MANNER OF DEATH 1 Neturel 5 Pending 2 Accident Investigation	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME O	M 1 V		26d. DE	SCRIBE HOW I	NJURY OCCUR	ED		
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify,	- At home, larm, stree)	et, factory, office		28f. LOC City	ATION (Street e or Town, Stete)	end Number or i	Rou	ite Number,	
COMPLETED		CIAN: To the best of my knowled I: On the basic of exemination e							ouse(e) e	nd manner ee s	tated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	lucalto	Nus		29c. LICENSE NUN				GNED (M	N 199	
	30. NAME AND ADDRESS OF PERSON WHO ANURITA M	ENDHIRA"	TTA '	2401	Resea	wil	E BL	VD R	bCk	2089 Wille	60
	31. DATE FILED (Month, Day, Year)	32. BEGISTRAR'S SIGNAT	P								





1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR		CE	:KI IFI	CALE	OF DEATH		REG. NO.			
	1. OECEDENT'S NAME (First, Middle, Last)						2. 0	ATE OF DEATH			3. TIME OF OEATH
	WALTER L	EROY ZAI	RGER					EB 2,	199	5	1:45 P M
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. lest	birthday)	IF UNDER t YE	AR IF UNDER 24 HRS.	7. D.	ATE OF BIRTH			PLACE (State or Foreign
- 4	214-07-6310	1 🖾 M 2 🗆 F	81	YRS.	WONTHS DA	YS HOURS MIN.		Month, Day, Year)	10	Country	0
	9a. FACILITY NAME (If not institution, give	etmat and number)	01		at OUTY TO	WN OR LOCATION OF		or 2, 19			MD
ا ۾	11637 Brehm Road						DEATH			INTY OF DE	
DIRECTOR	RESIDENCE OF DECEDENT	1 SE			Cumb	erland		-	AI	.legar	ny
<u>입</u>	10a, STATE 10b, COUNT	Y		10c CITY	TOWN OR L	OCATION					10d. INSIDE CITY
<u>=</u>	MD All										LIMITS?
		egany		Cum	berla						1 X YES 2 NO
≅	100. STREET AND NUMBER	a on				10f. ZIP CODE			-		HAT COUNTRY?
μ	11637 Brehm Road	1 SE				21502			US	A	
FUNERAL	11. MARITAL STATUS	t2. WAS DECEDENT E FORCES? t	VER IN U.S. ARI	MED	13. WAS	OECENDENT OF HISP	ANIC OF	HGIN? (Specify Yes	or No-	14. RACE	— American Indian, , Whita, atc.
BY.	1 Never Married 2 Married	IF YES, GIVE WAR		•		s, specify Cuban, Maxi- YES 2 X NO Spec		Prio Hican, etc.)		Specif	
	3 Widowed 4 Divorced										white
	15. DECEDENT'S EDU (Specify only highest grad	ICATION a completed)	18a. DEC	CEDENT'S U	SUAL OCCU	PATION g most of working	$\neg \tau$	16b. KIND OF BUS	INESS/IN	DUSTRY	
m	Elementary/Secondary (0-12)	College (1-4 or 5+)	lile.	Do NOT use	retired.)	•					
<u> </u>	12		Sp	pinnir	ng Dep	ot.	_	Texti.	le		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S	IAME (FI	irst, Middle, Maiden :	Sumeme)		
	Clarence E. Z	arger				Mary	Be	ll (Clin	germ	nan)	
BE	19e. INFORMANT'S NAME (Type/Print)		19b	MAILING A	ADDRESS (St	reet and Number or Rura			_		
임	James C. Zarger		111	637 F	Rrohm	Road SE;	Cami	borland	MD	215	02
	20a. METHOD OF DISPOSITION		20b. PLACE A				_			- City or Toy	
	t X Burial 2 ☐ Cremation 3 ☐ Ran 4 ☐ Donation 5 ☐ Other (Specify)	noval from Stata	cemetery cres	natory or oth	er nlace)						
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	1 22 Pe	ter F		emetery E AND ADDRESS OF I			iber.	land,	MID
		7.1.		1/		rpelli Fu					
	James	+ WICe	MARI		_ Cim	herland	MD	21502			
	23. PART i. Enter the diseases, pr	complications that c	aused the dec	eth. Do no	t enter the	mode of dying, au	ch es	cerdlec or reeple	ratory er	rest,	Approximate
	hock, or heart failure.	Liet Dnly Dne cause	on eech line.								Interval Between Onset and Death
	disease or condition	Corona	un at		do	ane					1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
H	reaulting in death)		R AS A CONSEQ	the same of the							years.
- 1	_		V	d							ľ
δ I	Sequentially liet conditiona,	DUE TO (OF	R AS A CONSEO	UENCE OF			-				
CERTIFICATION	If any, leeding to immediate cause. Enter UNDERLYING										
윤	CAUSE (Diseese or Injury that initiated eventa	C. DUE TO (OI	AS A CONSEO	UENCE OF							
ĘΙ	resulting in death) LAST										i l
		d		·							
CAL	PART II. Other algnificent condition	ns contributing to de	eath but not re	eulting in	the under	iying ceuee given i	n Part	I. 24a. WAS AN			WERE AUTOPSY FINDINGS
2								PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
								1 🗌 YES 2	LIMO		OF DEATH?
Σ	DID TORACCO LISE	CONTRIBUTE	CALLS	F OF	DEATU	VEC ET N		,			1 TES 2 NO
SICIAN:	DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL	CONTRIBUTE	IO CAUS	E OF				<u> </u>			
ᅙ	EXAMINER?	HOSPITAL:		1	OTHER:	8. PLACE OF DEATH (C	Check on	ly one)			
YS	1 NES 2 NO	1 - Inpetient 2 - E	R/Outpatient 3			Home 5 Masidence	6 🗆 (Other (Specify)			
PHY	27. MANNER OF DEATH	28a. DATE OF IN. (Month, Day,	JURY Year)	26b. TIME INJU		NJURY AT WORK?	26d.	DESCRIBE HOW IN	JURY OC	CURED	
B	1 Natural 5 Pending 2 Accident Investigation				M 1	YES 2 NO					
	3 Suicide 6 Could not be	28s. PLACE OF II building, sto	NJURY - At hor	ne, term, sti	reet, tectory,	office		LOCATION (Street a City or Town, State)	nd Numbe	r or Rural Ad	oute Number,
۳.	4 Homicide determined		(-,,/)					City or lown, State)			
וב	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of my	knowledge des	th occurred	et the time	data and place, and de	en for the	anuaria) and man		-	
COMPLETED	(Check only one) 2 MEDICAL EXAMIN										and manner on elected
					,			and place, and			
W	29b. SIGNATURE AND TITLE OF CERTIFIE	" 40	2			29c. LICENSE N					(Month, Day, Year)
0	<u> </u>	Jan July	-17m			D3328	3 U		F	eb.2	1995
	30. NAME AND ADDRESS OF PERSON WI	V				, ,	-	145 01	F 4 4		
1	Dr. Sunil Gup			venu	ie; C	umberlar	nd,	MD 21	.502		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAPE	SIGNATURE								
- 1	FEB 0 3 1995 July	of thannance in	A CARLON								

BALTIMORE, MARYLAND 21215-0020 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with property in the Hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burns be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

DHMH-16 Rev 1/89

TO BE COMPLETED BY FUNERAL DIRECTOR

PHYSICIAN: MEDICAL CERTIFICATION

BY

COMPLETED

BE

OT

Amended #1 1/31/90 MOT

95, 04864

OF MARYLAND	/ DEPARTMENT	OF HEALTH AND	MENTAL HYGIENE
	ERTIFICATE	OF DEATH	REG. NO.

FOR		/ STATE OF I	MADVI AND	DEDART	BECNIT O	E HEALTH AND	15,0	mere	7	- / [7.	
1 - STATE REGISTRAR		STATE OF N				OF DEATH	MEN I	REG. NO.	4	(0.	
1. DECEOENT'S NAME (First,	, Middle, Last)	Panke	n Va	han	7.0	noyan	2. DAT	E OF DEATH		3.	TIME OF DEATH	1
7	4009	23/ D	ADKEL	1		1110991	MON	TH DA		YEAR 95 1	232	PM
4. SOCIAL SECURITY NUMB	41- 4	5. SEX	6. AGE (In yrs. ias	- //	IF UNDER 1 YE		. 7. DATI	E OF BIRTH 1	1	8. BIRTHPLA	ACE (State or Fore	eign
219-02-205	3	162 M 2 🗆 F	74	YRS.	AONTHS DA	AYS HOURS MIN.		ist 26.		Country) Leban	ion	
9a. FACILITY NAME (If not in				1		WN OR LOCATION OF	DEATH		9c. COUN	TY OF DEATI	Н	
HOLY	CRUSS	HOSPITA	-		816	UER SPR	WE		Ma	UTGO	MERY	
10a. STATE	10b. COUNTY	Y		T 10c. CITY.	TOWN OR L	OCATION						
Maryland	Мо	ntgomery	nt come vy						d. INSIDE CITY LIMITS? YES 2 N	10		
10e. STREET AND NUMBER						101. ZIP CODE			10g. CITIZ	EN OF WHAT	T COUNTRY?	
409 Burnt 1	Mills	Avenue				209	01			Leban		
1 Never Married & Married FORCES? 1 YES 2 X NO If yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White						American Indian. hite, etc.	١,					
3 Widowed 4 Divo	rced				'"	YES 2 XIO Spe	city:		- 1	Specify:		
15, DEC	EDENT'S EDU	CATION	16a, Df	ECEDENT'S US	SUAL OCCU	PATION	18	b. KIND OF BUS	INESS/INDU		WITE	
(Specify onl) Elementary/Secondary (0	y highest grade		(G	live kind of wor Do NOT use i	rk done durin	ng most of working	1	W. 10110 C. C. C	111200	31111		
12	-12)	College (1-4 or 5+	+)	acher				Educa	tion			
17. FATHER'S NAME (First, M.	Viddle, Last)					18. MOTHER'S I	NAME (First,	Middle, Maiden				
Vahan Zanoya						Isku	hi Ja	mbazia	n			
19a. INFORMANT'S NAME (7)	ype/Print)		19	b. MAILING A	DORESS (St	treet and Number or Run	A Route Nur	nber, City or Town	, State, Zip C	Code) 2	0901	
Maro Zanoyar						ills Aven	ue Si	lver S	pring	_	0 2 0 2	
20a. METHOD OF DISPOSITI	n 3 🗆 Rame	oval from State	cometany cre	AND DATE OF	ar placel		1			Ity or Town,		
4 🖺 Donation 8 🗆 Other	(Specify)		- Gate	of He	aven	Cemetery	1/31/	958ilv	er Sp	ring,	Marvlar	hd
21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEE			22. NAW	ME AND ADORESS OF I	FACILITY					
1 in 17	11.11	40	1.	1 .		cis J. Co						
JUNION	MYS	Y). Cay	MODE	Cl.	500	Universit	y Blv	d., W.	Sil.S	pr.,M	D 20901	1
	eart fallure.	complications that List only one cau	t coused the de see on each line	ath. Do not	t enter the	mode of dying, au	ich ae cai	rdiac or reapir	atory arre	et,	Approximate Interval Bets	tween
IMMEDIATE CAUSE (Fin disease or condition							41			-	Onset and I	Death
resulting in death)	→	a. MAS	SLUE	LEF	T CE	REBRAC	NE	MORRI	4KE E		3 Da	45
		DUE TO	(OR AS A CONSEC	DUENCE OF):								
Sequentially list conditi		DUE TO	(OR AS A CONSEC	OUENCE OF):					-			
if any, leading to immed cause. Enter UNDERLY!	NG			70						j		
CAUSE (Disease or Inju	ry	DUE TO	(OR AS A CONSEC	OUENCE OF):						i		
resulting in death) LAS	т		(01.1.0.1.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						j		
		4.										
PART II. Other algnifice	nt condition	e contributing to	deeth but not r	esulting in	the under	lying ceuee given i	n Part I.	24a. WAS AN		24b. WE	RE AUTOPSY FIND	DINGS
	A) /0						PERFORI	WED?		MILABLE PRIOR TO	

1 TYES 2 700

OF DEATH? 1 YES 2 TNO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square

25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO 28. PLACE OF OEATH (Check only one)

Inpatient 2 - ER/Oulpatient 3 - DOA

4 Nursing Home 8 Residence 8 Other (Specify) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED

28a. DATE OF INJURY (Month, Day Ybar) 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office building, alc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number City or Town, Stete)

29a. CERTIFIER

In my opinion, death occurad at the time, data and place, and due to the ceuse(a) and manner as stated. 29c. LICENSE NUMBER

unD EVITAL

D14646

29d. DATE SIGNED (Month, Day,

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MALTUS - PUSCUTIVAL ULD. 10 10810 CONNECTIONS AUE, MARTIN KENSULE

31. OATE FILED (Month, Day, Year)

JAN 31

27. MANNER OF DEATH

1) Natural

2 Accident

3 Sulcide

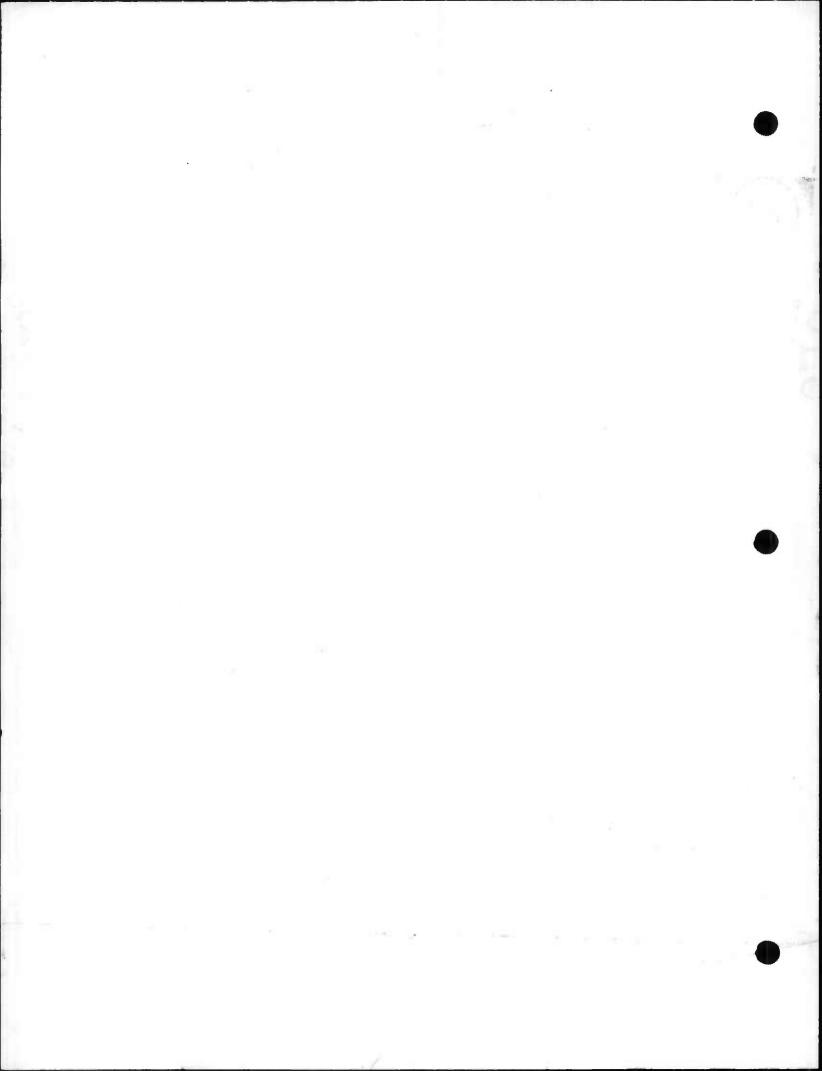
4 Homicide

32. REGISTRAR'S SIGNATURE
Julia Davidson Rardall

DHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within X hours after death. Page 6 may be retained by the law requires that the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 Is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760



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BALTIMORE	
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P.O. BOX 6870	
CORDS, P.	
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DIVISION OF VITAL RI

with. 24 hours after death. Page 6 may be retained by the hospital or attending physician.	stely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page	smation, or removal.	nt, the medical examiner must be notified at once.
40SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death. Page 6 may	physician and completely filled in by the funeral director,		PORTINE II liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified
(F)	P	1	Ē

s 1, 2, 3 should

DIRECTOR

FUNERAL

BY

COMPLETED

BE

2

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

2

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR Elizabeth Anderson 10:10Pm 5 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year, IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign Country) MONTHS DAYS HOURS 1 M 2 0 216-03-7375 YRS. 86 5-25-08 VA Sa. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH John Hopkins Bayview Medical Baltimore RESIDENCE OF DECEDENT 10a. STATE 10h COHNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Baltimore Turners Station 1 YES 2 KNO 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 141 Fleming Dr 21222 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE - American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Married 2 Married Specify: Black 1 TYES XXNO Specify: 3 ₩Vidowed 4 Divorced 16a. OECEDENT'S USUAL OCCUPATION

16a. OECEDENT'S USUAL OCCUPATION

Working most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest g (Give kind of work done life. Do NOT use retired.) Baltimore County Elementary/Secondary (0-12) College (1-4 or 5 +) Janitorial Services School Systems 17, FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname, Henry Flowers Annie Floyd 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20746 Raymond Alston 3845 St. Barnabas Rd. apt. 204 Suitland, MD 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE 1)2) Furial 2 Cremation 3 Ramoval from State
4 Donation 5 Other (Specify) cemetery, cremetory or other place) Voshells Memorial Baltimore, MD E OF FUNERAL SERVICE LICENSEE 22. NAME AND AGORESS OF FACILITY James A. Morton & Sons Funeral HOm 1701 Laurens St. Balto., MD 23. PART I. Exter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiec or respiratory arrest, anock, or heart failure. List only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Final **Onset and Death** diseese or condition Sepsis ? reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? 246. WERE AUTOPSY FINDINGS MAJLABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 27

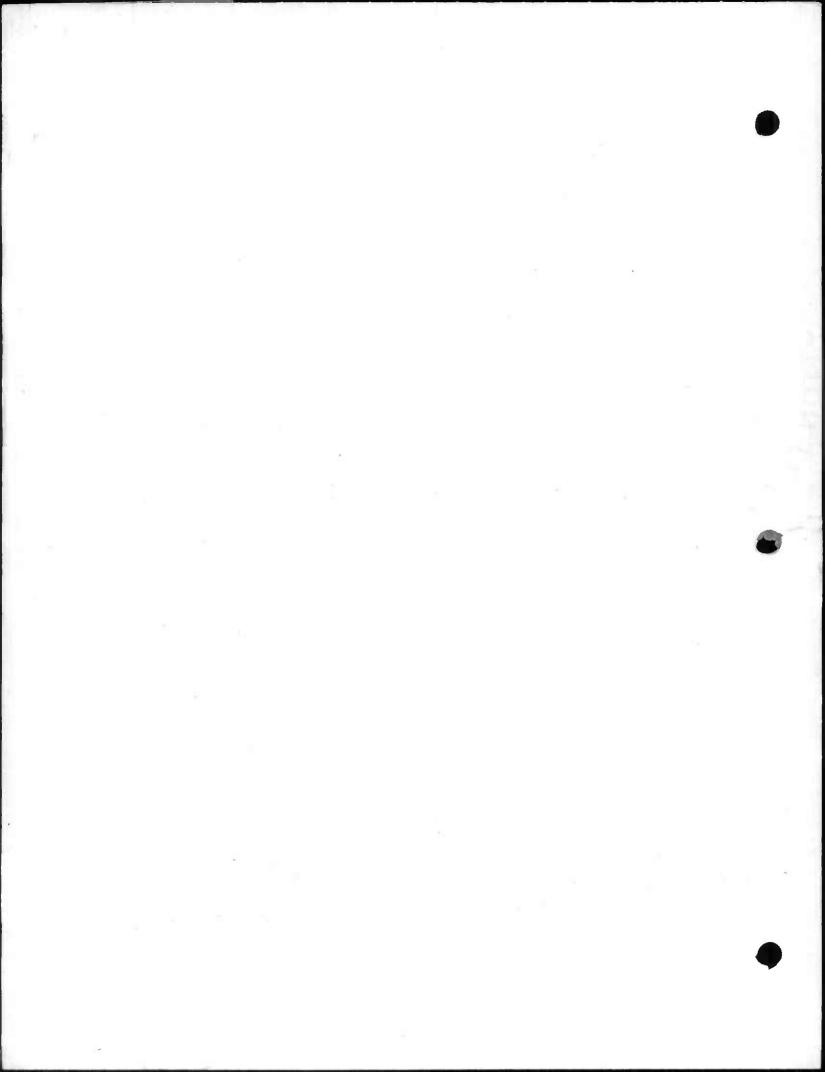
20. 100 CHOL HEI ENNEO TO MEDICAL	26. PLACE OF DEATH (Check only one)								
EXAMINER?	HOSPITAL:		OTHER: 4 Nursing Home 5 Rasidence 5 Other (Specify)						
27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	28c. INJURY AT WORK? 1 YES 2 NO	28d. OESCRIBE HOW INJURY OCCURED					
3 Suicide 6 Could not be determined	28a. PLACE OF INJURY — At hom building, atc. (Specify)	e, farm, street,	fectory, office	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
anal .				ue to the cause(s) and manner as stated. ne time, data and place, and dua to the cause(s) and manner as stated,					
29h. SIGNATURIFAND TITLE OF CERTIFIE	9		F-12-117-117-117						

2 MEOICAL EXAMINER: On the basis of axamination and/or investigation, in my opin	ilon, death occured at the time, data and place, a	nd dua to the cause(s) and manner as stated
SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d, DATE SIGNED (Month, Day, Year)

LETED CAUSE OF DEATH (ITEM 27) (Type, Print)

4940 Eastern Ave Balto Steven , MO 21224 W FEB 1 6 1995

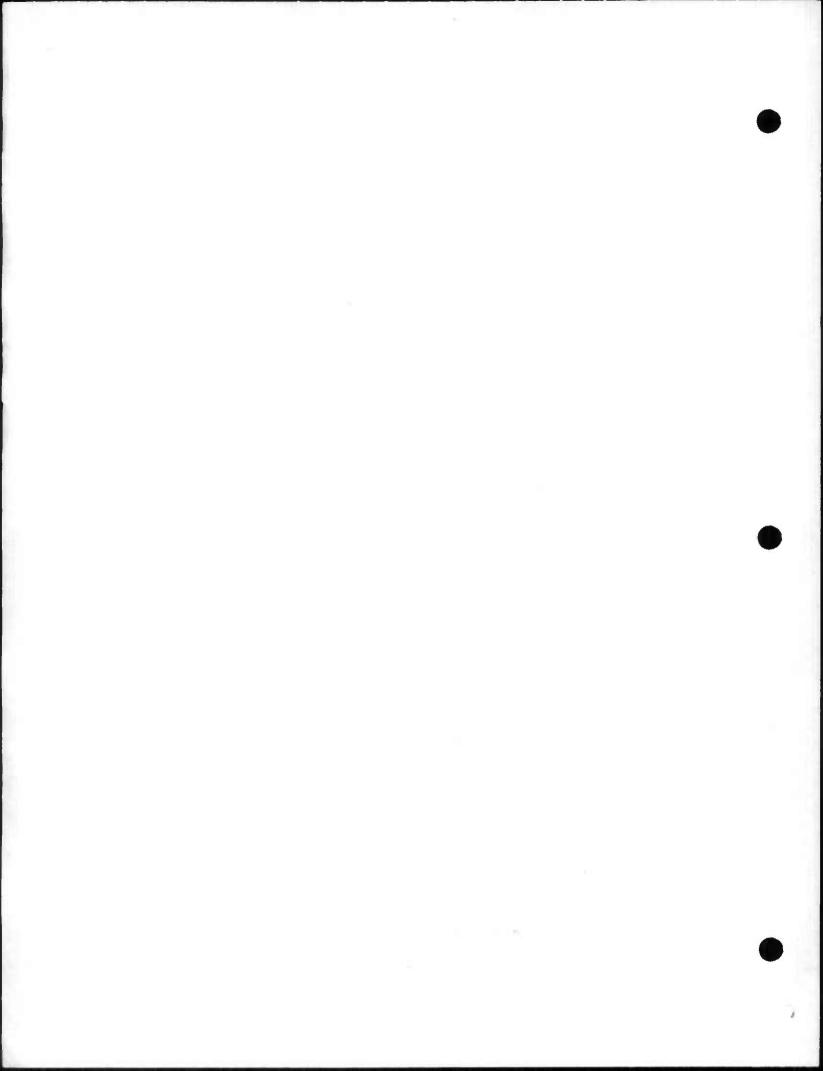
94008 > 2/13/95



DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within =5 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Panes 1 2 3 should	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	APORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
THE HO	THE FU!	be filed with	MPORTA

	1 - FOR STATE OF MARYLAN	ND / DEPARTI			MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3.	TIME OF OEATH	1
	Frances Catherine Bremer				February	^{AY} 8 1	995	10:55	ам
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In)	yrs. last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	- 1	8. BIRTHPLA	ACE (State or For	
	215-12-3420 1□ M 2 🗓 8	6 YRS.	DAYS DAYS	HOURS MIN.	March 15	1908	Country)	ylvani	
	Se. FACILITY NAME (If not institution, give street and number)	9	b. CITY, TOWN C	R LOCATION OF O			TY OF DEAT		4
OR	Augsburg Lutheran Home	- 11	Baltimo	re		Ralt	imore		
DIRECTOR	RESIDENCE OF DECEDENT					IXXX	LINIL	-	
E	102.000111		TOWN OR LOCAT				10-	d. INSIDE CITY LIMITS?	
	Maryland Baltimore	Uwin	gs Mill					YES 2 X N	10
FUNERAL	7 Haines Court			ZIP CODE				T COUNTRY?	
빌				1117			ed St	ates	
립	1 Never Married 2 Married FORCES? 1 YES	2 X NO	13. WAS DEC	ENDENT OF HISPA cify Cuban, Mexico	NIC ORIGIN? (Specify Yes	or No-	14. RACE — Black, W	American Indiar	١,
В	3 X Widowed 4 Divorced IF YES, OIVE WAR OR DATE	ES .	1 TES	2 X NO Specif	fy:		Specify:	White	
	15. DECEDENT'S EDUCATION 16	6a. DECEDENT'S US	UAL OCCUPATIO	N .	16b. KIND OF BU	SINESS/INDI	ICTOV	WILLEC	
	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of work life, Do NOT use n	k done during mo	at of working	Total Killio of Bo	3114233711424	osini		
립		Homemake	r		Own Hor	ne.			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NA	AME (First, Middle, Malden			_=	
	Edward McDowell			Theresa			ker		
BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAILINO AD	DRESS (Street a	nd Number or Rural	Route Number, City or Tow	n, State, Zip	Code)		
۱۹	Carole Gross				s Mills, M				
	20e. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Removal from State	ACE AND DATE OF I	DISPOSITION /No.	me of			aty or Town,	State	
	4 Donation 5 Other (Specify) Mor	ry, crematory or other eland Me	morial	Park	2/11 Car	nev.	Mary1	land	
- 1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AN	D ADDRESS OF FA	CILITY				
	Attack Attack		Mitch	ell-Wie	defeld Home	e, Inc	c.		
	23. PART I. Enter the diseasea, or complications that caused the	he death. Do not	enter the mor	York Roa	ad Baltimon	ce. Ma	arylar		
	snock, or heart failure. List only one ceuse on each	h iine.	ontor the mo	ie or dying, add	in an column or respi	ratory arre	sat,	Approximat Interval Bet	ween
	IMMEDIATE CAUSE (Final disease or condition	n:						Onset and	Death
ł	resulting in death) a. Alzheimer's								
_	_	one de la comp							
<u>ō</u>	Sequentially list conditions, if any, leading to immediate	ONSEQUENCE OF):							
3	cause. Enter UNDERLYING								
	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CO	ONSEQUENCE OF):				-			
CERTIFICATION	resulting in death) LAST		_						
	PART ii. Other algnificant conditions contributing to deeth but	not resulting in t	he underlying	cause olven in	Part i. 24a. WAS AN	AIPPORAV			
SAL SAL		not resulting in t	ine underlying	couse given in	PERFOR		AWA	RE AUTOPSY FINI VILABLE PRIOR TO	
					1 _ YES 2	NO	OF	MPLETION OF CAI DEATH?	
Σ	DID TOPACCO LICE CONTRIBUTE TO CALICE OF	DEATH VEC	El vo M	141.405054.41			10	YES 2 NO	·
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF 1	PLACE OF DEATH		UNCERTAI	иш				
ᅙ	EXAMINER? LIQSPITAL:	0	THER:		1	. \ .	N.7	·	
<u>¥</u>	1 YES 2 NO petient 2 ER/Outpetle 27. MANNER OF DEATH 28s. DATE OF INJURY					led in		1 4	
	1 Natural 5 Pending (Month, Day, Year)	28b. TIME O	/ WOI	RK?	28d. DEŞCRIBE HOW II	NJURY OCCI	URED		
à l	2 Accident Investigation	A1 hanna da		ES 2 NO					
	3 Suicide 8 Could not be 4 Homicide 8 Could not be datermined	At nome, term, stree	et, tectory, office		28t. LOCATION (Street a City or Town, State)	nd Number o	or Rural Route	Number,	
<u> </u>	29a. CERTIFIER								_
COMPLETED	(Check only 1 PCEHTIFYING PHYSICIAN: To the best of my knowledge								
ᅙ 	one) 2 MEDICAL EXAMINER: On the beals of examination an	nd/or investigation, i	n my opinion, de	ath occured at the	time, data and placa, an	d due to the	cause(a) and	d manner as stat	led.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUI		29d. DATE		oth, Day, Year)	
0	X			03	15 13	•	2/10	195	
	30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH JEF 71601 MV 7.77			Λ Λ	0 11	, A	۸		
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BALLIMORE, MARTCAND 21215-0020	law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	as been signed by the attending physician and completely for the funeral director, page 5 should be detached for use as the burial-transit permit. Pages and Abenta Havingson price, to burial, examples on the funeral Havingson price, to burial, examples
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LAECOADS, P.O. BOA 86/60	lres t	Signed
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STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) Peter 2. DATE OF DEATH 3. TIME OF DEATH 1995 A_{M} COLIANO FEB. 13 11:40 ANGELO 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign Month, Day, Year) 11/21/1914 DAYS HOURS 1 M 2 | F 80 216-32-6866 Maryland 1, 2, 3 should 9e. FACILITY NAME (If not institution, give etreet end number) 9b. CITY, TOWN OR LOCATION OF GEATN 9c. COUNTY OF DEATH DIRECTOR BAYVIEW MEDICAL CENTER BALTIMORE 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel Linthicum 1 - YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 18g. CITIZEN OF WHAT COUNTRY? 705 Green Tree Road 21090 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☑ NO Specify: 11 MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Married BY Specify: 3 🔀 Widowed 4 🗌 Divorced White 16a. DECEDENT'S USUAL OCCUPATION

"The kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Years Business Owner Self Employed 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 76 Antonio Coliano BE Estelle Colavo notified 190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Linda Lucas 2304 Maple Road Edgemere MD 21219 pe 20e. METNOD OF DISPOSITION
2 Burlei 2 □ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 4 Donation 5 Other (Specify) Most Holy Redeemer Cem. 2/17/95 Baltimore, MD 21. SIGNATURE OF PUMERAL SERVICE LICENSE examiner 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate shock, or heart failure. List only one ceuse on each line. **IMMEDIATE CAUSE (Final** Onset and Death the state of disesse or condition GUNSHOT OF CHEST event, reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST 0 injury, PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL any 1 YES 2 NO COMPLETION OF CAUSE shows : 1 - YES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 DIVISION OF VITAL 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) this certificate h Hem HOSPITAL OTHER: 1 YES 2 NO 1 Dipatient 2 ER/Outpatient 3 DOA ATTENDING PHYSICIAN: rsing Home 5 - Residence 8 - Other (Specify) 6 28a. DATE OF INJURY marked, 28b. TIME DF INJURY 28c. INJURY AT 28d. DESCRIBE HDW INJURY OCCURED 1 Netural 5 Pending SUBJECT SHOT 2 13 95 1200pm 1 YES 2 NO After the BY 2 Accident 28e. PLACE OF INJURY — At homa, farm, street, fectory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town State) COMPLETED 8 Could not be NO DIRECTOR: hours after 4 Homicide 28 datermined 205 1/2 WISED UF BAUTIMOREUS BO. 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(e) end menner ee atsted. (Check only one) TO THE HOSPITAL
TO THE FUNERAL I
DE filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) end manner ee stated. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Ubrel FEB. 14, 1995 Shill O.C.M.E. 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HISHIPP BOD D Worker wy 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Tali Stavilson Rendell FEB 1 6 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Martha Ellen Chew

Chew

CERTIFICATE OF DEATH

FOR STATE REGISTRAR

1. DECEMENT'S NAME (First, Middle, Last)

1 -

4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS 212-30-6603 1 M 2 F 92 2-3-1903 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR MD. GENERAL HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10e STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION MD BALTIMORE permit. I FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burlal-transit 1514 McCULLOH ST. 21217 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 1 Never Merried 2 Merried If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 YES 2 NO Specify BY 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION 5 15. DECEDENT'S EDUCATION (Specify only highest grade co-(Give kind of work done life. Do NOT use retired.) H Elementary/Secondary (0-12) College (1-4 or 5 +) DOMESTIC WORKER COMP UNKNOWN 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) te CHARLES CHEW BE MARTHA ELLEN CHEW notified 199. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM CHEW 1514 McCULLOH ST. BALTIMORE MD 21217 pe 20e. METHOD OF DISPOSITION 206_PLACE AND DATE OF DISPOSITION (Name of must 1 N Buriet 2 Cremetion 3 Removal from State
4 Donation 8 Other (Specify) LORRAINE PARK 2/18/95, medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME P.A. funeral after death. 1300 EUTAW PLACE BALTO. MD 21217 the 23. PART J. Enter the diseases, or complications that caused the storm. Do not anter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live. filled in by t IMMEDIATE CAUSE (Final the cremation. disease or condition Respiratory Failure Secondary to Congestive completely DUE TO (OR AS A CONSEQUENCE OF): Obstructive Pulmonary Disease unknown resulting in death) other traumatic event. DIVISION OF VITAL RECORDS, P.O. BOX 68760, executed with burial, Pulmonary Hypertension
OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION and Sequantially list conditions, prior to If any, leading to immediate cause. Enter UNDERLYING attending physician CAUSE (Disease or injury Hygiene QUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 the atten PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t Health and any Shows 3 certificate has been h the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN IN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) **EXAMINER?** OTHER: 1 TYES 2 NO V☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Realdance 8 Other (Specify) 0 27. MANNER OF DEATH 28e. OATE OF INJURY with t marked, 28b. TIME OF 28c. INJURY AT WORK? 1 X Natural INJURY 5 Pending Investigation DIRECTOR: After the hours after death w М 1 YES 2 NO ВY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, offica building, atc. (Specify) 00 3 Suicide 8 Could not be COMPLETED 28 4 Homicide Item 1 [X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, end due to the cause(s) end manner as stated. TO THE HOSPITAL
TO THE FUNERAL I
De filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data end place, end due to the cause(s) end manner es stated. 29b. SIGNATURE AND TITLE OF CERMILER 29c. LICENSE NUMBER BE 89231 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kam AuYeung, M.D. c/o Maryland General Hospital

> 32 REGISTRAR'S SIGNATURE whi Studen Ra

95 04868 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG NO 2. DATE OF DEATH 3. TIME OF DEATH 14 95 9:05 A 8. BIRTHPLACE (State or Foreign MD 9c. COUNTY OF DEATH 10d. INSIDE CITY TYES 2 NO 10g, CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, etc. Specify: BLK. 16b. KIND OF BUSINESS/INDUSTRY BALTO. MD Approximata Onset and Daath 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES XXNO OF DEATH? 1 TYES 2 T NO 28d, DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNEO (Month, Day, Year) 2-14-95

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	
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31. DATE FILED (Month, Day, Year)

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

TONDALAYO

5. SEX

DAYS HOURS 1 🗌 M 2 💢 F 577-76-1950 YRS. 39 permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 4413 - 23rd Parkway, #201 RECTOR Temple Hills, RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION M.D. ā Temple Hills, P.G. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 20748 4413 23rd Parkway, #201 use as the burial-transit 12. WAS DECEDENT EVER IN U.S. ARMED Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puerto Rican, atc.)
1 YES 2 NQ Specify: ALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2.
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 3 Widowed 4 Divorced ETED. 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) (Specify only highest grade for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Computer Operator 12th the funeral director, page 5 should be detached 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maid Doris Ferguson Dodd notified at Carl Dodd, Sr. 19a. INFORMANT'S NAME (Type/Print 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2510 Eliot Place, Temple Hills, Md. 20748 2 Carl Dodd, Sr. þe 20e. METHOD ON DISPOSITION

1 Buriel 2 Cremetion 3 Re
4 Donation S Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of must cemetery crematory Crematory examiner MERAL SERVICE LICENSES #866 after medical ss, of complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrest, failure. List only one cades on each line. filled in by strock, or hea 0 IMMEDIATE CAUSE (Final event, the disease/or conditio Cancer of the breast with metastasis completely resulting in death) DUE TO (OR AS A CONSEQUENCE OF): and com o burial, traumatic CERTIFICATION Sequentially list conditions, 0 DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate physician cause. Entar UNDERLYING CAUSE (Diseese or injury or other the attending phy 1 Mental Hygiene OUE TO (QR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL signed by the any shows a 0 peen has be Dept. PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN IN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) item State **EXAMINER?** HOSPITAL: OTHER: 1 X YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Nome 5X Residence 8 Other (Specify) 6 the 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME QF 26c. INJURY AT WORK? this c marked. INJURY 1 XNetural 5 Pending 1 YES 2 NO ВҰ After Investigation 2 Accident 28s. PLACE QF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 28 is COMPLETED 6 Could not be DIRECTOR: / 4 Nomicide detarmined item 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. THE HOSPITAL OF THE FUNERAL D filed within 72 ho TO THE FUNERAL ID THE FUNERAL ID Effed within 72 h 2 😾 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTA 29c. LICENSE NUMBER 8 D21230 ugust todring Vm

30. NAME AND ACCRESS OF PERSON WHO COMPLETED CALLE OF CEAT) (ITEM 27) (Type, Print)

32 REGISTRAR'S GNATURE

Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748-2230

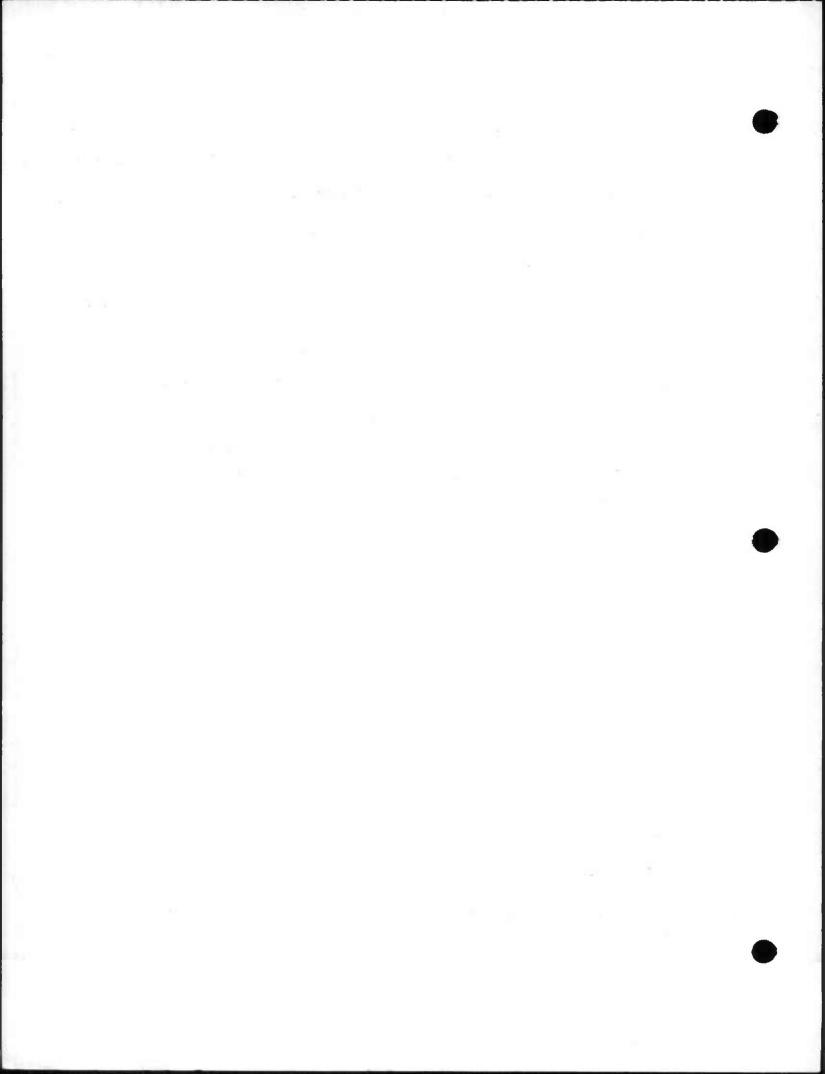
CERTIFICATE OF DEATH

DODD

6. AGE (In yrs. last birthday)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2. DATE OF DEATH 3. TIME OF DEATH 09 1995 February 7a. 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1/21/56 Washington, DC 9c. COUNTY OF DEATN P.G. 10d. INSIDE CITY 1 X YES 2 | NO 10g. CITIZEN OF WHAT COUNTRY? **USA** 14. RACE — American Indian, Black, White, etc. Black 16b. KIND OF BUSINESS/INDUSTRY Eddie Mache Company 2/15/95 Clinton, Md. Robert G. Mason Funeral Home, Inc. 1661 Good Hope Road, S.E., DC 20020 Approximate Intarval Between Onset and Death 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINOINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 1 TYES XX NO DE OFATNO 1 YES 2 NO 28d, DESCRIBE HOW INJURY OCCURED 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)

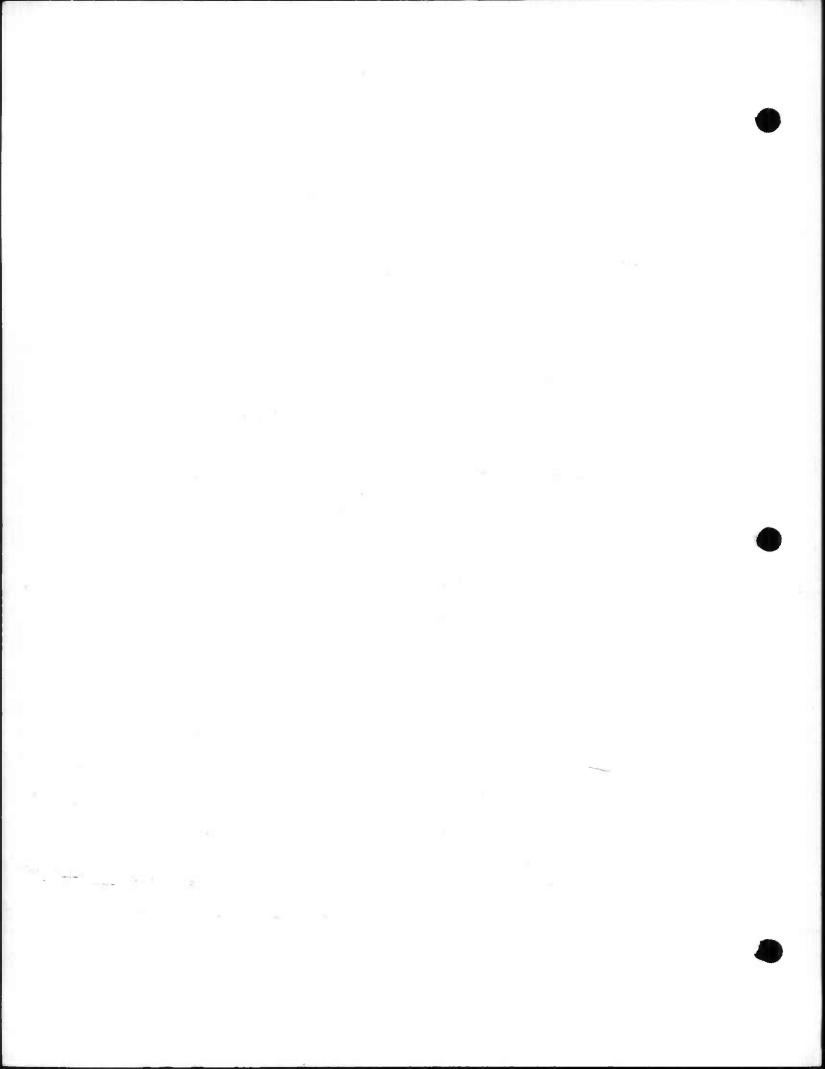
≥9d. DATE SIGNED (Month, Day, Year)
February 9, 1995



ITEMS: 23 PART I, II, 27, PER MEO FILM G-721 3/10/95 t.t.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH **JAMES** LYAL DERRY JR. FEB 14 1995 8:25P 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day, Year) an. 19,1952 215-60-3205 1 X M 2 - F 43 Jan. Maryland permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1305 W. NORTHERN PARKWAY Baltimore City. 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1305 West Northern Pkwy. and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit or burial, cremation, or removal. 21209 USA retained by the hospital or attending physician, 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ▼ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuban, Maxican, Puerto Rican, stc.)

1 YES 2 XNO Specify: 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married Specify White BY 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spi (Give kind of work done life. Do NOT use retired.) College (1-4 or 5+) 10th Greenskeeper Private Golf Course once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) James Lyal Derry, Sr. T BE Tommie Jean Harper notified 19a. INFORMANT'S NAME (Type/Print, 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5 Tommie Jean Derry 3838 Roland Ave. Apt. 1105 Balt. MD 21211 Раде 6 тау be pe 20a. METHOD OF DISPOSITION
1 Burlai 2 CCremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State must Metro Crematory, Inc. 02/15/95 4 Donation 6 Other (Specify) Baltimore, MD Cremation Society of Maryland, Inc. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE hours after death. George E. MacNabb 299 Frederick Rd. Baltimore, MD 21228 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata & ahock, or heart failure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Final** Onset and Death 静 disease or condition ATHEROSCLEROTIC CARDIOVASCULAR DISEASE resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): executed traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 9 the attending physician Mental Hygiene prior to if any, leading to immediate the death certificate be cause. Enter UNDERLYING other 1 CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by the PERFORMED? AVAILABLE PRIOR TO any CIPRHOSIS OF THE LIVER, DIABETES MELLITUS, RENAL ABSCESSES COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO been of of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The Item certificate h HOSPITAL: L DIRECTOR: After this certificate hours after death with the State 1 YES 2 NO □ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Homa 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) this c marked, 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 XX Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY - At home, term, street, factory, office 3 Suicida 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 6 Could not be COMPLETED 4 Homicide Item 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. Fibera. 2 🔀 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER D D S IN THE STATE OF 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) hute us O.C.M.E. FEB 15, 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis J. 111 Penn Street, Baltimore, Maryland 21201. Chute 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE FEB 6 1995



FOR STATE REGISTRAR

t. DECEOENT'S NAME (First, Middle, Last)

Edwards Dennis Royce 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS 1 🔀 M 2 🗌 F 43 217-54-8754 permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Howard County General Hospital Columbia 10e STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION Elkridge Elkiidge Md. Howard FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE burial-transit 6193 Old Washington Rd. 21227 Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried
3 Widowed 4 Divorced FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 TYES 2 NO Specify ВY use as the ED 15. DECEDENT'S EQUCATION 16e. DECEDENT'S USUAL OCCUPATION. (Specify only highest grade compi (Give kind of work done during most of working life. Do NOT use retired.) ET the funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Clerk notified at once. t7. FATHER'S NAME (First, Middle, Last) Ludwell Edwards BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 bbie Debbir Edwards Road, Montivideo pe 20a, METHOD OF DISPOSITION
1 Surfel 2 Cremetlon 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACEAND DATE OF DISPOSITION (Name of DATE must 2/14 Meadowridge Memorial Park 21. SIGNATURE OF FUNDRAL SERVICE LICENSE examiner 22. NAME AND ADDRESS OF FACILITY ours after death. 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory errest, shock, or heart indire. List only one ceuse on each line. removal. medicai filled in by 0 IMMEDIATE CAUSE (Final has been signed by the attending physician and completely fille Dept. of Health and Mental Hygiene prior to burial, cremation, the disease or condition incumon. resulting in death) other traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF) OUL TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury QUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL any shows DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 1 PHYSICIAN: UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) r this certificate his with the State C item HOSPITAL: OTHER: 1 TES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 10 27. MANNER OF DEATH DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? marked. 1 Natural 1 YES 2 NO DIRECTOR: After the hours after death v BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 50 3 Sulcide COMPLETED 8 Could not be 28 4 Homicide item OR 29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date end place, end due to the cause(e) end manner ee stated. FUNERAL I = 2 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7. 296. SIGNATURE AND TITLE OF CERTIFIER 20c. LICENSE NUMBER D2070 BE OB Nellan 10 5 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

- 10 WC

32. REGISTRAR'S SIGNATURE

11055

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 2. DATE OF DEATH 3. TIME OF OFATH 1995 3:40 A February 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Washington. March 13. DC 9c. COUNTY OF DEATH Howard 10d. INSIDE CITY t YES 2 YNO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, etc. Specify: white 18b. KIND OF BUSINESS/INDUSTRY U. S. Post Office 18. MOTHER'S NAME (First, Middle, Maiden Surname) Evelyn Miller Jessup, Md. 20794 20c. LOCATION — City or Town, State Elkridge, Md. Gary L. Kaufman Funeral Home of Elk., Inc. Approximate intervsi Between Onset and Deeth 24b. WERE AUTOPSY FINOINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO OF DEATH? 1 YES 2 NO 26d, DESCRIBE HOW INJURY OCCURED 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) 29d, OATE SIGNED (Month, Day, Year) MA

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TO BE COMPLETED

ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within a flor death. Page 6 may be retained by the hospital or attending physician.

The this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should must be state Dept. or Health and Mental Hyglene prior to burial, cremation, or removal. m 28 is marked, or liem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

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	1 - FOR STATE REGISTRAR	STATE OF M				HEALTH AND	MENTAL HYGIEI REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)	Fo	720 W	,	.70		2. DATE OF DEATH	3	YEAR 95	3. TIME OF DEATH 0445 M
	4. SOCIAL SECURITY AUMBER 214–26–5216	5. SEX t M 2 - F	6. AGE (In yrs. less	YRS.	IF UNDER 1 YEAR		June 10,1	919	Country	PLACE (State or Foreign)) Th Carolina
O.B.	99. FACILITY NAME (If not institution, give s Carroll County Ge		spital			on Location of Di tminster	EATH	9c. COL	Car	eath Croll
ច្ឆ	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Υ		10c CIT	Y. TOWN OR LO	ATION			т	
DIRECTOR	Maryland	Howard		100. 011		tt City				10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 3006 D Autumn Bi	anch Lane	9			101. ZIP CODE 2104	43	1 -	U.S.A	HAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 X Merried 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1. IF YES, GIVE WI W W I	P YES 2 N	WED	If yes,		NIC ORIGIN? (Specify Year, Puerto Rican, etc.)		14. RACE	- American Indien, , White, etc.
COMPLETED	t5. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-t2)		(Gi	ve kind of a Do NOT us	USUAL OCCUPA work done during se retired.)	TION most of working	166. KIND OF BU			nent
BE CON	17. FATHER'S NAME (First, Middle, Lest) John Easom					16. MOTHER'S NA Alice S	ME (First, Middle, Malder			
TO B	190. INFORMANT'S NAME (Type/Print) Catherine Robinso	n (Frie	nd) 30	MAILING 006 D	ADDRESS (Street	n Branch I	Route Number, City or Tox Lane Ellic	vn, Stete, Zi	City,	1043 Maryland
	20e. METHOD OF DISPOSITION 1 □ Burlel 2 反 Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	ovel from State	20b. PLACE A Cernatery, crea		of Disposition ther place)	Name of 02-14-95			City or Ton	wn, State e, Maryland
	21. SIGNATURE OF SUBSERIAL SUBSINICE LIG	With.	1		Lero		cury sell C Wit	zke I	Funer	-
	23. PART I. Enter the disease of ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Card	io puli	чоч	ary	Arrest.	h aa cardlac or reap	iratory ar	теві,	Approximate interval Batween Onset and Daath
RTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING	b. 1) End-S DUE TO (OR AS A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECU	UENCE OF DUENCE OF CA	2) A	a Pathy	uh Cez k 4) A Cuti Failure	leco	1	2/10/95 T://
CERTIFIC	CAUSE (Disease or injury that initiated eventa resulting in death) LAST	failure	OR AS A CONSEO	UENCE OI	/(Mul	ti-organ	failure	with.	sepsi.	2/13/95 63 hours
PHYSICIAN: MEDICAL C	PART II. Other eignificant condition							AUTOPSY		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
N. M	DID TOBACCO USE CONT	RIBUTE TO CAL	JSE OF DEAT	TH YE	S NO	UNCERTAIN	<u> </u>			1 ☐ YES 2 ☑ NO
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACI	OF DEAT	OTHER:	e)				
I XSI	1 YES 2 NO	1 Inpetient 2 🗆			4 - Nursing H	ome 5 🗆 Reeldence	6 Other (Specify)			
H	27. MANNER OF DEATH	26e. DATE OF I (Month, Da	NJURY r, Year)	28b. TIM		NJURY AT YORK?	26d. DESCRIBE HOW	INJURY OC	CURED	

261. LOCATION (Street and Number or Rural Route Number, City or Town, State)

25. WAS CASE REFERRED TO MEDICAL EXAMINER?		CE OF DEATH (Check	only one)		
	HOSPITAL: 1 Inpetient 2 ER/Outpatient 3	OTHE	R: raing Home 5 - Residence	6 Other (Specify)	
27. MANNER OF DEATH t Natural 5 Pending 2 Accident Investigation	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	26c. INJURY AT WORK?	26d. DESCRIBE HOW INJURY OCCURE	

28e. PLACE OF INJURY — building, etc. (Specify) 3 Suicide

S WET	EXAMPLER: On the	e beele of examination	on end/or inveatigation, in my opinion, d	eath occured at the time, date end piece, er	nd due to the ceuse(e) and menner ee stated.
WX W	Se centrules	1,m.)	(M.D.)	29c. LICENSE NUMBER D-4020	29d. DATE SIGNED (Month, Day, Year) ▶ 2/14/95

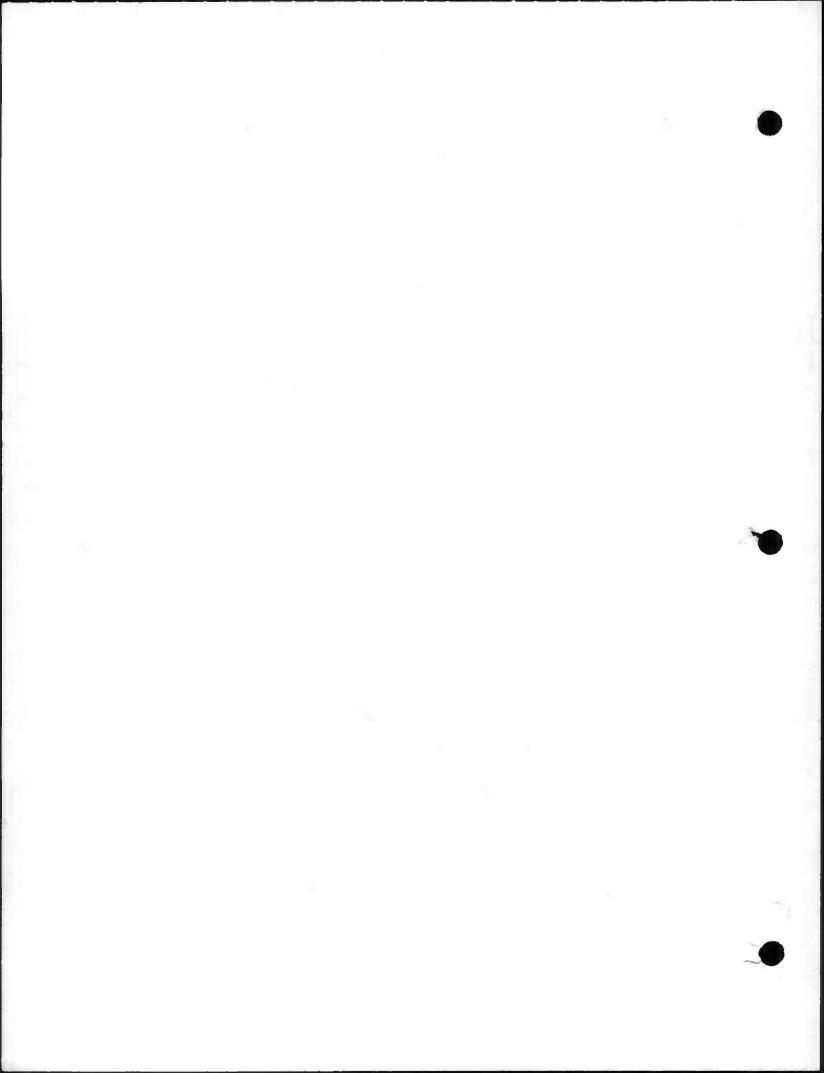
AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

FARZAD ASSAR, M.D. / 1502 S. MAIN ST., MT AIRY, MD FARZAD

32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year)

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	0
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	PROTEIN OR APPROPRIES OF PROPERTY THE PROPERTY OF THE PROPERTY

		1 - FOR STATE 0	F MARYLAND / DE	EPARTMENT OF H		NTAL HYGIENE REG. NO.					
		1. DECEDENT'S NAME (First, Middle, Last)				DATE OF DEATH DAY	YEAR 3. TIME OF DEATH				
pp		4. SOCIAL SECURITY NUMBER 5. SEX 216-03-8254 1 🖾 M 2		thday) IF UNDER 1 YEAR YRS. MONTHS DAYS	IF UNDER 24 HRS. 7. HOURS MIN.	DATE OF BIRTH (Month, Day, Year) De tober 8, 190	8. BIRTNPLACE (State or Foreign Country) MARYLAND				
2, 3 should	CTOR	99. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BALTIMORE									
it. Pages 1,	DIREC	RESIDENCE OF DECEDENT 100. STATE MARYLAND BALTIMORI		DG. CITY, TOWN OR LOCAT BALT	IMORE		10d. INSIDE CITY LIMITS? 1 YES 2 NO				
n. ansit permit.	VERAL	10e. STREET AND NUMBER 6946 COPPERBEND LANE		101.	ZIP CODE	10g.	CITIZEN OF WHAT COUNTRY? USA				
215-0020 attending physician. se as the burial-transit	BY FUN	1 Never Married 2 Merried FORCES?	DENT EVER IN U.S. ARMED 1 YES 2 X NO VE WAR OR DATES		cify Cuben, Mexican, F	ORIGIN? (Specify Yes or No Juerto Ricen, etc.)	14. RACE — American Indian, Black, White, etc. Specify: WHITE				
6 2	LETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4	(Give ki life. Do i	ENT'S USUAL OCCUPATIO ind of work done during mos NOT use retired.)	N st of working	MENS CLO	S/INDUSTRY				
YLAND 2 by the hospital t be detached to at once.	E COMPL	12 17. FATHER'S NAME (First, Middle, Last) SOLOMON EPSTEIN	SAL	<u> </u>	18. MOTHER'S NAME REBECC	(First, Middle, Maiden Surner					
MAR e retained 5 shouk notified	TO BE	190. INFORMANT'S NAME (Type/Print) MRS. ANN KURLANDER				e Number, City or Town, State BALTIMORE,					
e 6 m		20s. METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	20b. PLACE AND I cometery. cremato RIGA	DATE OF DISPOSITION (National Control of Con	EREIN -	2-15-95 ROS					
SAL death e fune al.		· allensue	Leven.	6010	REISTERS		ALTIMORE, MD 21215				
octificate be executed within a pours nating physician and completely filled in thygene prior to bunal, cremation, or reproduced to the medical professional control in the medical profession of the medical professional profess	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	cause on each line.	ypertens we on: ACCI	10		Approximata interval Between Onaat and Death				
signed by the Health and M	MEDICAL C	PART ii. Other significent conditions contributing	; to death but not reaul	iting in the underlying	ceuse given in Par	1 L YES 2 TO NO	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
has been Dept. of 23 she	SICIAN: N	DID TOBACCO USE CONTRIBUTE TO 25. WAS CASE REFERRED TO MEDICAL		YES NO D	UNCERTAIN		1 YES 2 NO				
	PHYSIC		2 ER/Outpatient 3 D	OTHER: 4 Nursing Home	5 Residence 8	Other (Specify) d. DESCRIBE NOW INJURY	OCCUPED				
DING PHYS After this death with	ВУ Р	1 Natural 5 Pending 2 Accident Investigation (Mon	(m) 091. (ogr)	M 1 Y	RK? ES 2 NO						
OR ATTENDING PHYSICIAN: DIRECTOR: After this certifications after death with the St.	ETED	4 Homicide determined	CE OF INJURY — At home, t ling, etc. (Specify)			f. LOCATION (Street and Nui City or Town, State)					
単元 =	COMP	(Check only one) 2 MEDICAL EXAMINER: On the basis									
TO THE HOSPI TO THE FUNE DO THE WITHIN	TÓABB	29h. SIGHATORE AND TITLE OF CERTIFIER 30. MAME AND ADDRESS OF CERTIFIER 30. MAME ADDRESS OF CERTIFIER 30. MAME AND ADD	CAUSE OF DEATH (ITEM 27)		2402321	B19834 >	Forway 13, 1995				
		31. DATE FILED (MONTH) Day, 1601) FEB 1 6 1995 Julia day	2435 W STRAR'S GRATURE LOCKARDALL	le Kelvede	re Baltin	nose, hel	21215				



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \text{Meturs after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF M	ARYLAND /	DEPARTM	ENT OF I	HEALTH AND	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last) SHERMAN			EFLAND		DEATH.	2. DATE OF DEATH	AV YE	3. TIME OF OEATH 7 30 P M
	4. SOCIAL SECURITY NUMBER 046-22-8301 9a. FACILITY NAME (If not institution, give st	1 M 2 F	6. AGE (In yrs. las 65	YRS. MON		IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year) MAY 5,19	- C	IRTHPLACE (State or Foreign ountry) ONNECTICUT
STOR	6142 FORTY WINKS	INKS WAY COLUMBIA HOW						OF DEATH HOWARD	
DIRECTOR		HOWARD		12.	WN OR LOCAL UMBIA	TION			10d. INSIDE CITY LIMITS? 1 X YES 2 NO
FUNERAL	100. STREET AND NUMBER 6142 FORTY WINKS				10	1. ZIP CODE 21045			OF WHAT COUNTRY?
BY FU	11. MARITAL STATUS 1 Never Married 2 💢 Married 3 Nidowed 4 Divorced	12. WAS DECEDENT FORCES? 1 V	YES 2 P		II yes, sp	CENDENT OF NISPA secify Cuban, Maxic 3 2 X NO Speci	NIC ORIGIN? (Specify Yea an, Puerto Rican, etc.) fly:		RACE — American Indian, Black, Whita, etc. Specify: WHITE
COMPLETED	15. OECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(G	CEDENT'S USUA ive kind of work of Do NOT use reti	lone during mo	ON ost of working	16b. KIND OF BU	SINESS/INDUSTF	
MP.	12			X - R	AY TEC	CHNICIAN		GOVER	NMENT
	17. FATHER'S NAME (First, Middle, Last) NATHAN	म	FLAND			18. MOTHER'S N. ANNA	AME (First, Middle, Maiden		ICHTN
TO BE	19a. (NFORMANT'S NAME (Type/Print)		191			and Number or Rural	Route Number, City or Tow	n, State, Zip Code	
	MRS MARILYN 20a, METHOD OF OISPOSITION 1 Burlel 2 Cremation 3 Ramo	EFLAND	20b.PLACE	AND DATE OF DIS	SPOSITION (Na	ame of		CATION — City of	r Town, Stata
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL-SERVICE LICE	ENSEE	COL	JUMBIA	MEMOR 3	IAL PARK	2-14-95 (COLUMBI	A, MD
	Loes!		/ ~ · · = · ^		SOL	LEVINSO	N & BROS.,		
	23. PART J. Enter the diseases, or co	οπιρίζαtions that	caused tha da	ath. Do not a	6010	REISTE	RSTOWN ROAL th as cardiac or respi	BALTII	MORE, MD 21215
	iMMEDIATE CAUSE (Final disease or condition	lat only one caus	on sech line	nic.	,		,	, , , , , , , , , , , , , , , , , , , ,	Interval Between Onset and Death
z	resulting in death)	Metro	TANT	SIMA	ll C	ell lu	nez Celin	CV.	6 MOS
CATIO	Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury	Metastato Small Cell lung Clince. 6 Mos.							
CERTIFICATION	that initisted events resulting in deeth) LAST	OUE TO (C	OR AS A CONSEC	DUENCE OF):					
- 1	PART II. Other algnificent conditions	contributing to d	eeth but not n	eculting in th	e underlyin	g cauea given in	Part I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL			<u> </u>				PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
N.									
SIC!		HOSPITAL:			HER:	ACE OF DEATH (C)			
	27. MANNER OF DEATN 1 V Netural 5 Pending	28e. DATE OF IN (Month, Day)	JURY	28b. TIME OF INJURY	28c. INJ WO	URY AT	8 Other (Specify) 28d. OE\$CRIBE NOW II	NJURY OCCURED)
ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF building, at	INJURY — At hore. (Specify)			YES 2 NO	281. LOCATION (Street a City or Town, State)	and Number or Ru	rel Route Number,
COMPLETED							to the cause(a) and man		
CO	2 MEDICAL EXAMINER								ne(a) and manner as stated.
BE	296. SIONATURE AND TITLE OF CERTIFIER W. EMM	irele	LM J).		29c. LICENSE NU	339	≥ 29d. DATE SIGN	NED (Morrin Day, Year)
2	30, NAME AND ADDRESS OF PERSON WHO		1			1/31		4	17()

PLETEO CAUSE OF DEATH (ITEM 27) (Typo, Print)

2 KNOW

12. REGISTRAR'S SIGNATURE
Jahr Dhullon Randall

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31. DATE FILED (Month, Day,

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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH John Richard Frazier 1995 14. *Eebruary* 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday) 7. DATE OF BIRTH (Month, Day, Yea B. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. 217-38-4584 55 1 X M 2 T F DAYS HOURS MIN. YRS 11-16-1939 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR 3946 Loch Leven Drive Havre de Grace Harford RESIDENCE OF DECEDENT 10b. COUNT 10a STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Harford Havre de Grace Maryland permit. 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10o. CITIZEN OF WHAT COUNTRY? United States 21078 3946 Loch Leven Drive use as the burial-transit retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yee, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 24 1 X Never Married 2 Married 1 TYES 2 NO NO Specify BY Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade College (1-4 or 5+) funeral director, page 5 should be detached for Elementary/Secondary (0-12) 9 years Laborer Box Factory 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Charles Joseph Frazier, Sr. Isabel Florence Frazier 76 notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. William Frazier 3946 Loch Leven Drive Havre de Grace, Md. 21078 2 pe METHOD OF DISPOSITION
Burtal 2 Cremation 3 Parmoval from State
Donation 5 Other (Specify) hours after death. Page 6 may 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State must 2-16-930 Cak Tawn Cenetery Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner Duda-Rick Funeral Home of Dundalk, Inc. Vacqu 7922 Wise Avenue Dundalk, Md. 21222 filled in by the medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart latiure. List only one cause on each line. Approximata Interval Between 0 IMMEDIATE CAUSE (Final **Onset and Death** Respiratory failure Bronchop relumonia the disease or condition resulting in death) the attending physician and completely in Mental Hygiene prior to burlal, crematic event, poorly differentiated

Bone metastasis berable 0 traumatic CERTIFICATION Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate the death certificate be Bone CRUSA Enter UNDERLYING and CAUSE (Disease or Injury QUE TO (OR AS A CONSEQUENCE OF): that initiated events regulting in death) LAST 0 PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS Health and MAR ABLE PRIOR TO obstructive pulmonary disease any COMPLETION OF CAUSE OF DEATH? 1 - YES 2 has been signe b Dept. of Healtl n 23 shows a 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN NA PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h the State 1, or item HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) 1 YES 2V NO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT NA 28d. DESCRIBE HOW INJURY OCÇUREO marked, this c Nonth, Day 1 Natural 5 Pending NAM 1 YES 2 NO DIRECTOR: After the hours after death BY Investigation ATTENDING 2 Accident 28s. PLACE OF INJURY — At home, farm, atrael, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6/3 COMPLETED 6 Could not be 4 Homicide NA 50 determined Tem S. 29a. CERTIFIER NECERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. FUNERAL C within 72 h 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 295 SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Huthullers MD INTERNIST 2/4/95 5 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo. Print) POTOMAC PHYSICIANS, 104 PLUMTREG MUTHULAKS HMII RAMESHMD RD SUITE IIS BELAIR MD-21014 BELAIR MD- 21014 31. OATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURE

Julia Davileon Revolath

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STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH FEBRUARY 13, 1995 JUDITH 7 am FRANK 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year)
AUG. 7,1933 IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 XXF 217-30-2999 DAYS HOURS 61 YRS MARYLAND Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR 2824 DAMASCUS COURT, APT. D BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE permit. 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? burial-transit 2824 DAMASCUS COURT, APT. D 21209 USA retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuban, Mexicen, Puerto Rican, etc.)

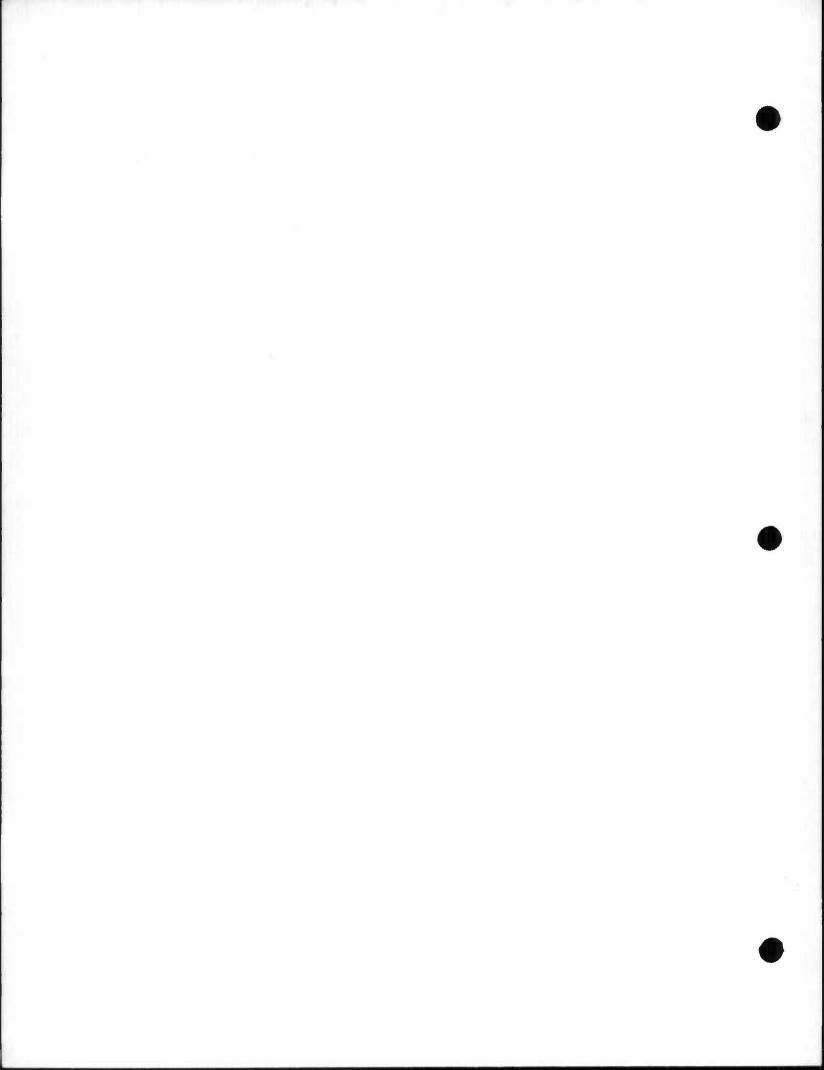
1 YES NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married B Specify: 3 Widowed 4 Divorced use as the WHITE 16a. DECEDENT'S USUAL OCCUPATION

16a december of work done during most of working 6 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY Ш funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 MEDICAL SECRETARY HOSPITAL Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname Ħ **JACOB** BE KAPLAN MOLLIE KESSLER notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 MISS ESTELLE 2707 JENNER DRIVE, APT. KAPLAN C BALTIMORE, MD 21209 Page 6 may be must be 20a. METHOD OF DISPOSITION

1X Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, Stata SHAAREI ZION 4 ☐ Donation 5 ☐ Other (Specify) _ 2-14-95 ROSEDALE, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 2121 completely filled in by the fal, cremation, or removal. medical 23. PART I. Enter tha disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory streat, Approximata ahock, or heart failure. List only one cause on each line. Interval Between 9 IMMEDIATE CAUSE (Final Onsst and Death cremation, the Corenony of Meluz disease or condition_ nelosilate event, reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) in and cont to burial, traumatic CERTIFICATION Sequentially list conditions. OUE TO (OR AS A CONSEQUENCE OF): if sny, laading to immediata physician Cause, Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 Mental the PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? by t U51/2 signed t 1 TYES 2 T NO OF DEATH? 1 TYES 2 T NO 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) State HOSPITAL: OTHER: 1 TES 2 WHO ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 the 27. MANNER OF DEATH 26e. OATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT marked, 26d. DESCRIBE HOW INJURY OCCURED with 1 Natural 5 Pending M BY 1 YES 2 NO After death 2 Accident 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcide after de 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED DIRECTOR determined MIT 72 hours a 29a. CERTIFIER (Check only one)

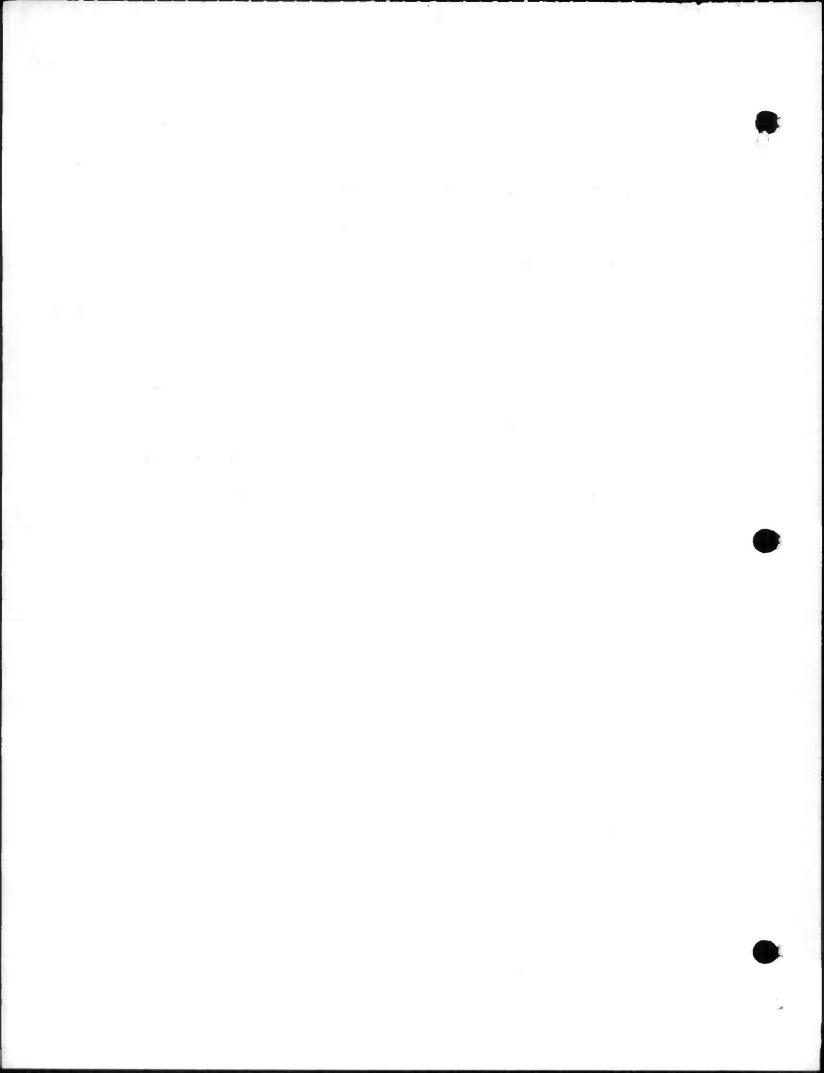
2 | MEDICAL EXAMINED: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as attated. besis of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the ceuse(a) and manner as stated. 29b. SIGNATURE AND THILE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 1644 emil 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) 32 DEGISTRAR'S CONTURE 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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		1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.
		1. DECEDENT'S NAME (First, Middle, Last) ANNA FOGLER 2. Date of Oeath MONTH Feb. 14, 1995 3. Time of Death To S Am
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs, last birthday) F UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) TO MORTINS DAYS UCURE Many (Month, Day, Year) Country)
3 should		9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH
2,	СТОВ	Meridian Nursing CtrTruckhouse Rd. Severna Park Anne Arundel
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permit. Pages 1, notified at once.	DIREC	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10c. CITY LIMITS? Maryland NA Baltimore (Brooklyn) 10d. INSIDE CITY LIMITS? 1 □ ▼ 1 □ ■ 1 □ ■ 1 □ ■ 1 □ ■ 1 □ ■ 1 □ ■ 1 □ ■ 1 □ ■ 1 □ ■ 1 □ ■ 1 □ ■ 1 □ ■ 1 □ ■ 1 □ ■ 1 □ ■ 1 □ ■ 1
	ERAL	10%. STREET AND NUMBER 3530 Fourth St. 10f. ZIP CODE 21225 USA
	BY FUNE	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 15 YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yee, specify Cuben, Maxican, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 15 YES, GIVE WAR OR DATES 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yee, specify Cuben, Maxican, Puerto Ricen, etc.) 16. RACE — American Indian, Black, White, etc. 17 YES, GIVE WAR OR DATES 18. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yee, specify Cuben, Maxican, Puerto Ricen, etc.) 19. Poerity: White, etc.
	PLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) 12th Grade 16b. KIND OF BUSINESS/INDUSTRY (Bive kind of work done during most of working life. Do NOT use refired.) Retired Self-employed Bakery Owner
	E COMPL	17. FATHER'S NAME (First, Middle, Last) Joseph Wasyl 18. MOTHER'S NAME (First, Middle, Malden Surname) Katie Sczur
	TO B	19a. INFORMANT'S NAME (Type/Print) Mr. Steven M. Fogler, Sr. 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Foxwell Bend, Glen Burnie, Md. 21061
Page 6 may be all director, page 5		20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Removal from State 4 Donetion 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, cremetory probler piace) Cedar Hill Cemetery 2/18/95 Baltimore, Maryland
SAL r death ne funer al.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin E. Ecker McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225
ours afte d in by th or remov		23. PART 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximate Interval Between
68760, secured within nd completely filled burial, cremation, tilc event, the		IMMEDIATE CAUSE (Finel disease or condition resulting in death) One to (OR AS A CONSEQUENCE OF): One of the condition as A CONSEQUENCE OF):
	Z	Sequentially list conditions, Due to (or as a consequence of): HYPEN (Calent A Due to (or as a consequence of):
SOX te be ex siclan a prior to	FICATION	cause, tentar UNDERLYING
S, P.O. BO death certificate a attending physi ental Hygiene pri iry, or other ti	ERTIFI	CAUSE (Disease or injury that initiated avents resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OR): VEAUS
- 2 2 E	0	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 24s. WAS AN AUTOPSY FINDINGS
res that igned beauth ar	MEDICAL	Perpheral Vascala 0, Serve 1 yes 2 no Performed? AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 yes 2 no
AL KE he law requi has been s e Dept. of H		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐
VII A HAN: The Triffcate I The State I Or Item	'SICIAN:	28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 1
NG PHYSICI fler this cer sath with th marked, o	ву рну	27. MANNEN OF DEATH 1 Netural 5 Pending 2 Accident Investigation 28a. OATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 1 YES 2 NO 28c. INJURY AT WORK? 1 YES 2 NO
AL OR ATTENDIAL DIRECTOR: A 2 hours after de fittem 28 is	ETED 8	3 Suicide 6 Couts not be determined 22a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 2as. LOCATION (Street and Number or Rural Route Number, City or Town, State)
	COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and dus to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.
TO THE HOSPITA TO THE FUNERA DE filed within 7	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) D297296 V(5/95)
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) GENALD M CONDEN MO DOJ E. FORT AVE. BULL 21230
		FEB 1 6 1995 Julio Sanisan Russes

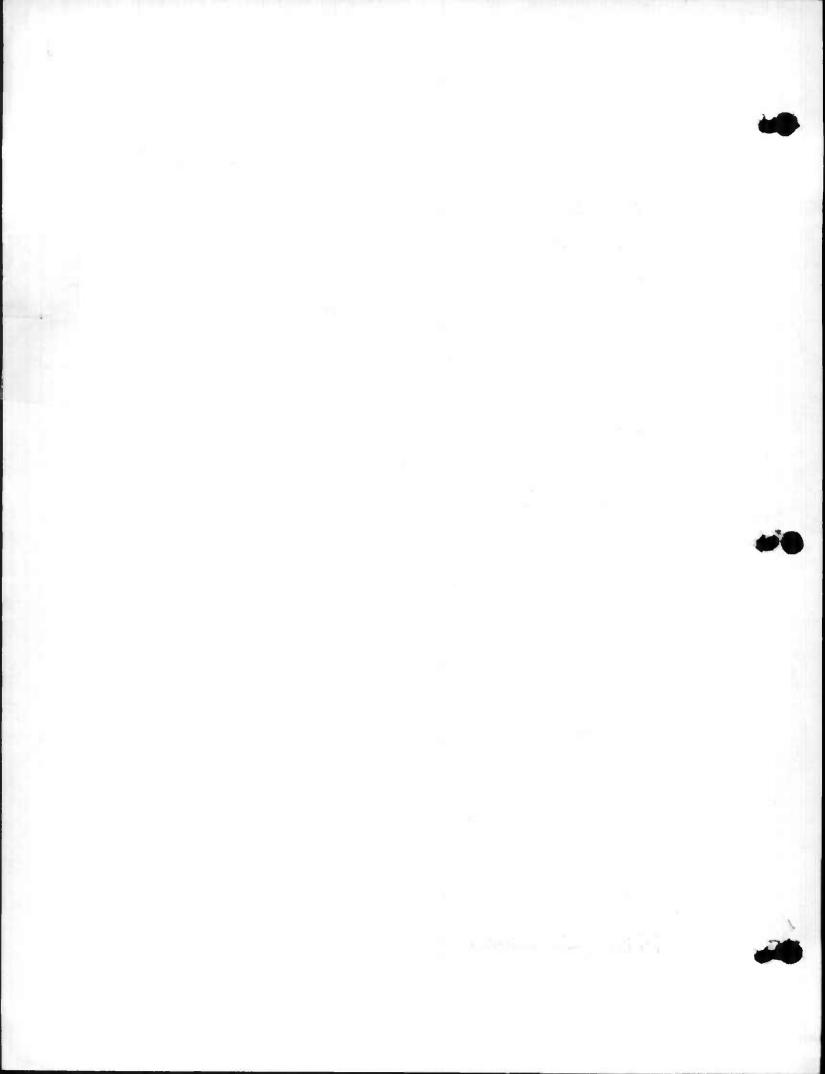


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VISION OF VITAL RECORDS, P.O. BOX 13146,	STTENDING DHYSICIAN: The law requires that the death certificate he executed within
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d in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should or removal. TO BE COMPLETED BY FUNERAL DIRECTOR urs after death. Page 6 may be retained by the hospital or attending physician. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crem. TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIM	E OF DEATH
ELEANOR GILL February 12, 1995 12	:40P M
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE	1191
212-34-5004 1 M 2 XXF 85 YRS. MONTHS DAYS HOURS MIN. JULY 17.1909 Maryla 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9e. COUNTY OF DEATH	ind
Meridian Multi-Medical Nursing Center Towson Baltimore	
10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. IN	NSIDE CITY
	YES 2 NO
1934 Ruxton Road 21204 USA	
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No — 14. RACE — Arm	ericen Indien,
1 Never Merried 2 Married FORCES? 1 YES 2 NO If yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White Specify: Spe	, etc.
A 1	White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use netted.)	
Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Health Care	
17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Melden Surname)	
Charles Coleman Mary Schultz	
19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)	
Carolyn Nicoll 228 Brackenwood Court Timonium, Maryland 21093	
20e. METHOD OF DISPOSITION 1	
21, SIGNATURE OF PUNERAL SERVICE LICENSEE 4 22. NAME AND ADDRESS OF FACILITY	
Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212	
23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or reepiretory street, shock, or heart fellure. Liet only one cause on each line.	Approximate interval Between Onset and Daath
IMMEDIATE CAUSE (Finel disease or condition resulting in death) S. Atheros devotic Carrior Carrior Scular Due to (or as a consequence of):	
Sequentially list conditions, Due to (or as a consequence of):	
If any, leeding to immediate cause. Enter UNDERLYING	
CAUSE (Disease or Injury Due TO (OR AS A CONSEQUENCE OF):	
resulting in deeth) LAST	
PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE	AUTOPSY FINDINGS
PERFORMED? AMALA COMPI	ABLE PRIOR TO LETION OF CAUSE
1 TYES 2 NO OF DE	
	YES 2 NO
25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)	
EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA APRILIPATION FOR SERIES OF THE	
27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DE\$CRIBE HOW INJURY OCCURED	
1 Natural 5 Pending (North, Day, real) 2 Accident Investigation M 1 YES 2 NO	
3 Suicide 6 Could not be determined 286. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 286. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)	umber,
29e. CERTIFIER (Check and Check and	
(Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) end in	nenner as stated.
29b. SIGNATURE AND THE OF CERTIFIER 29d. DATE SIGNED (Month	, Day, Year)
529770 February 14	4, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. Sergio Cassenego 8813 Walthan Woods Road Baltimore, Maryland 21234	
31 DATE FILED (Month, Day, Year) 22. REGISTRAR'S SIGNATURE	





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RECORDS, P.O. BOX 68760	
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29b. BIGNATURE AND TITLE OF CHRTIFIER

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TO WE MISSIMAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Jours after death. Page 6 may be retained by the hospital or attending physician.	TO THE CONTROLLAGE After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Places 1, 2, 3 should	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: Il Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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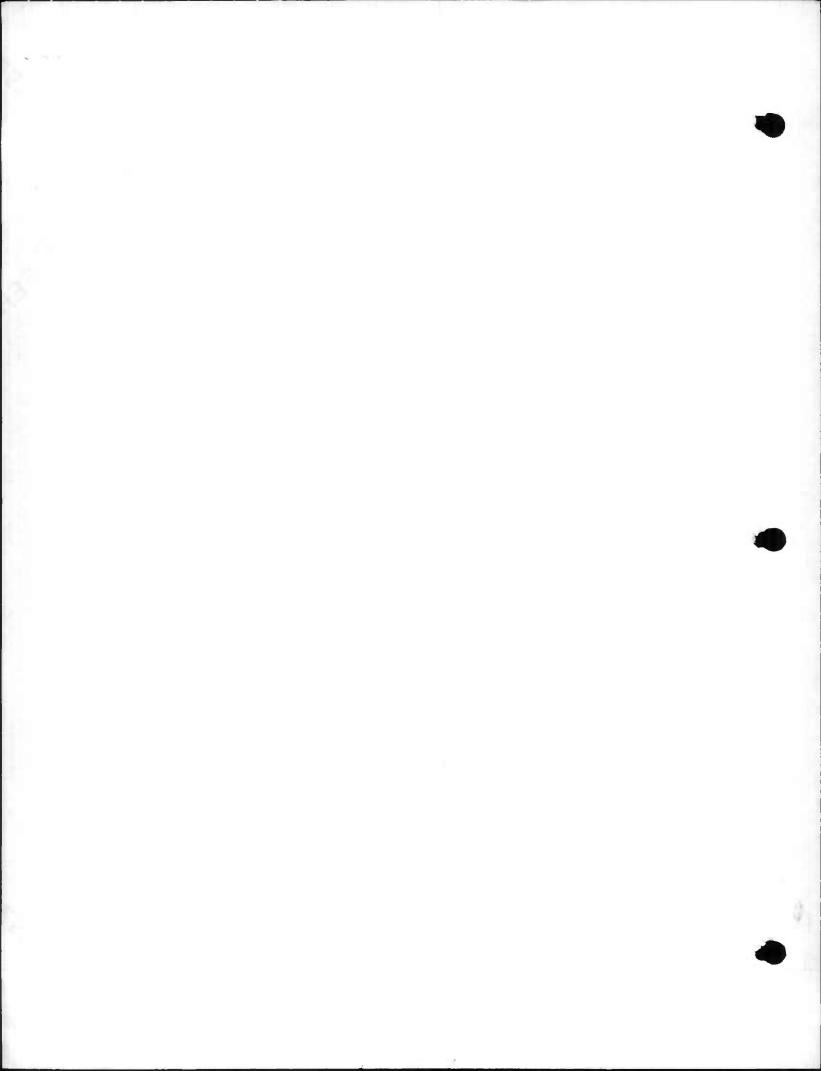
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Gat atrick Feb 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) 7. DATE OF BIRTH (Morth, Day, Year) JULY 12 1910 IF UNDER 1 YEAR | IF UNDER 24 HRS. 101-10-6970 IRELAND 1 X M 2 - F HOURS 84 YRS. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BON SECOUR EXTENDED CARE DIRECTOR ELLICOTT CITY HOWARD RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD HOWARD COLUMBIA 1 YES 2 N NO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 5345 HARPERS FARM ROAD 21044 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Pi 1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION ecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spec College (1-4 or 5+) RETAIL FOOD SUPERMARKET MANAGER NONE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname MICHAEL GAFFEY MARY HENSON BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 PETER WHEELER (SON-IN-LAW) 3238 BIRCHMEDE DR. ELLICOTT CITY MD 21042 20a, METHOD OF DISPOSITION
1 A Burlal 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Cametery crimatory or other place)

SI: CHEKLES CEMETERY FEB. 18 1995 LONG ISLAND N. Y. 4 Donation 6 Other (Specify) 21. SIGNATURE OF EUNERAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY LEROY M & RUSSELL C WITZKE FUNERAL HOME 5555 TWIN KNOLLS RD COLUMBIA MD 2145 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line. interval Betw Onset and Death **IMMEDIATE CAUSE (Final** disease or condition mos resulting in death) DUE TO (OR AS A CONSEQUENCE OF): huld car cenous CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A COL cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 10 NO 1 | YES 2 | NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) HOSPITAL: 1 - YES 2 1 NO 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED 28c. INJURY AT WORK? 5 Pending Investigation 1 Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Flural Floute Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 290. CERTIFIER 1X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated,

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ellicott City Alan G. Stah1 4801 Dorsey Hall Drive, Suite 201B 32 REGISTRAR'S DIGNATURE 31. DATE FILED (Month, Day, Year) D 16

tion and/or investigation, in my opinion, death occured at the time, date and place, and de

29c. LICENSE NUMBER



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

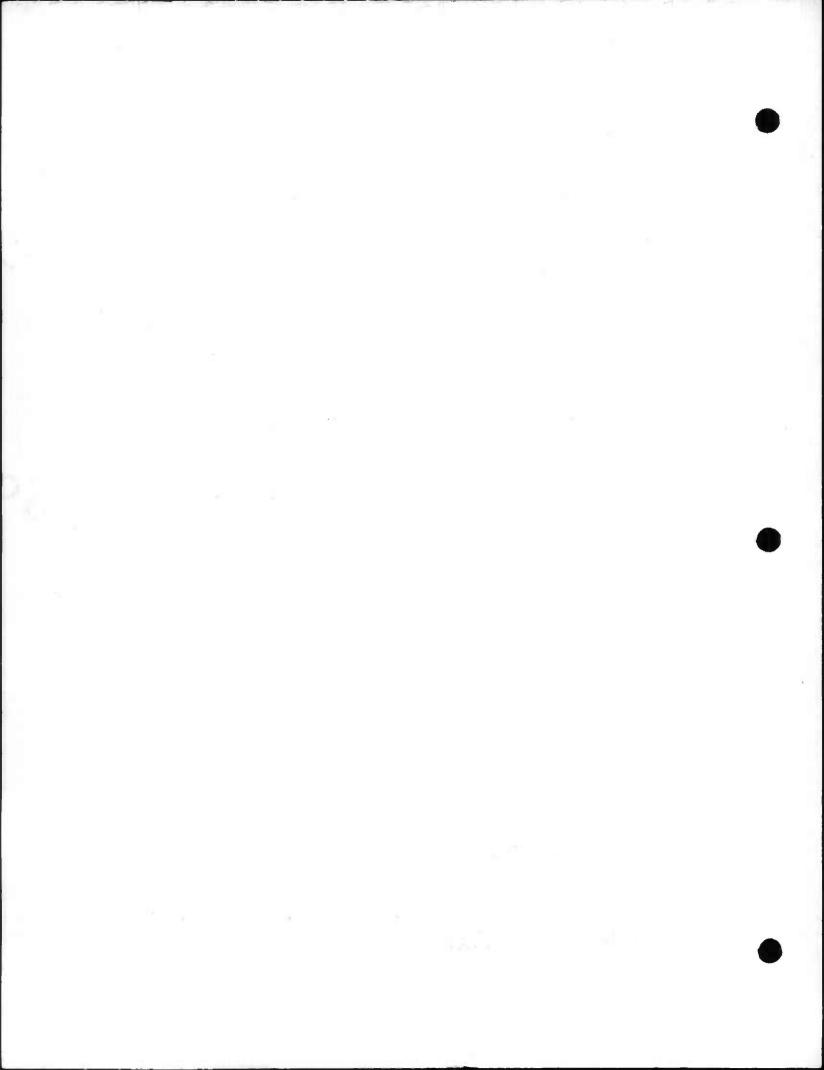
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	TIEGIGTTIAIT				CERTIF	ICALE	OF I	JEAIT	R	IEG. NO.			
- 1	1. DECEDENT'S NAME (First,	Middle, Last)					<u> </u>		2. DATE OF				3. TIME OF DEATH
- 3	,		_						MONTH	DAY		YEAR	S. TIME OF DEATH
	Robert		Eugene		Gaith	er			Feb	13	1.0	995	0602
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (in yrs.	lest birthday)	IF UNDER 1		IF UNDER 24 HRS.	7. DATE OF B			8. BIRTH	PLACE (State or Foreign
	220 42 070	20	1 M 2 - F	64	YRS.	MONTHS	DAYS	HOURS MIN.	(Month, De	y, Year)	~~ l	Countr	y)
	236-42-072			04					December	$\mathcal{L}(\mathcal{L}, \mathbb{I})$	_		: Virginia
	9e. FACILITY NAME (If not in:	stitution, give s	itreet and number)			9b. CITY, 1	TOWN OR	LOCATION OF D	EATH		9c. COU	NTY OF D	EATH
DIRECTOR	1712 ы т	ombas	cd C+~c	+		D	1 4 4			ľ			
F	1712 W. I.	EDENT	11 21 E			L_Ba		nore					
M	10a. STATE	10b. COUNT			10c. CIT	Y, TOWN OR	LOCATIO	ON .					10d. INSIDE CITY
E	Mal											- 1	LIMITS?
	Md.				Ba.	ltimo	re						1 X YES 2 NO
¥	10s. STREET AND NUMBER						101. 2	ZIP CODE			10g. CITI	ZEN OF V	HAT COUNTRY?
8	1712 W. L	onbar	d St.					21223				USA	
FUNERAL	11. MARITAL STATUS				750							OUN	
교			12. WAS DECEDEN FORCES? 1	YES 2	ARMED	13. W	AS DECEN	NDENT OF HISPA	NIC ORIGIN? (S	pecify Yes o	or No-	14. RACE	— American Indian, , White, etc.
BY	1 Never Married 2 XX		IF YES, OIVE W	AR OR DATES	7			NO Specif		i, etc.)		Speci	
	3 Widowed 4 Divo	rced	1			Ì		4	,			ф	"white
		EDENT'S EDU		16a.	DECEDENT'S	USUAL OCC	MOITAGLE		16P KIN	D OF BUSI	NECC (INC	HOTOM	
E		highest grade	completed)		(Give kind of a	work done du	ring most	of working	100. 1/11	D OF BUSH	NE33/INU	USINY	
ا ت	Elementary/Secondary (0-	-12)	College (1-4 or 5 a	+)									
COMPLET	8				Meat	t Cuti	cer		A	& P	Stor	es	
5	17. FATHER'S NAME (First, Mi	(ddle, Last)						18. MOTHER'S NA	ME (First Markett	a Maldan C.	anna mal		
	1.1-74 7	0	1								urrieme)		
B	Walter T.		ner					Daisy M					
	190. INFORMANT'S NAME (7)	rpe/Print)			19b. MAILING	ADDRESS (Street and	Number or Rural	Ploute Number, C	ity or Town,	State, Zip	Code)	
임	Bettv Gait	hor											,
- 1				_				rd St.,		., Ma	. <	122	3
	20e. METHOD OF DISPOSITI	n/3 Bam	oval from State	20b. PLA	CEANDDATE	FDISPOSIT	ION (Name	e of	DATE	20c. LOCA	ATION —	City or To	wn, State
	4 Donation 8 Other	(Specify)		The	Greet	ner piace)	nt C	emetery	2/16	Ral+	imor	0 1	1d
- 1	21. SIONATURE OF FUNDRAL	SERVICE LIC	ENSEE //		OLCCI	22 N/	AME AND	ADDRESS OF FA	CHIEV	Date	TIIIOT	C, 1	iu.
	. 9/		1	1		Gar	nv 1	Kaufm	an Fund	anal	Homo	of	Elk., Inc.
- 1	1.10	1	2 60	u lm	reng	001	Ly L	· Kaoriii	all Ulli	CIGI	Home	: 01	LIK., IIIC.
_	00 00001 54 48 8		P	- 55		1 56	95 M	ain St.	, Elkr	ıdge,	Md.	23	1227
- 1	23. PART I. Enter the disabook, or he	ert failure	List only one cau	t caused the	daeth. Do r	ot enter th	na moda	of dying, suc	h as cardiac	or respira	itory am	est,	Approximate
- 1	IMMEDIATE CAUSE (Fin		-iot only one can	ad OII GOCII I	iiig.								Interval Between
- 1	disease or condition		1.1		- 1	11.	-						Onset and Death
	resulting in death)	→	. Chr				SIN						ļ
- 1			DUE TO	(OR AS A CON	SEOUENCE OF	F):							
2													
ᅙᆘ	Sequentielly liet condition	ona,	bOUF TO	(OR AS A CON	SECULENCE OF	n.							
F	if any, leading to immed cause. Enter UNDERLY!!		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(01110) / 0011	DEGOLINOE OF	P							Ì
<u>3</u>	CAUSE (Disease or Injur		с										
<u> </u>	that initiated events		DUE TO	(OR AS A CON	SEQUENCE OF	7):							1
	reaulting in deeth) LAST												
CERTIFICATION			0										+
	PART ii. Other significes	nt condition	s contributing to	deeth but no	t resulting l	n the unde	erivina c	ceuse given in	Part I 24a	. WAS AN AL	ITOPEV	245	WERE AUTOPSY FINGINGS
5 I			_				,	Journal of the state of the sta		PERFORM		290.	AWAILABLE PRIOR TO
ž I									13	YES 2	NO		COMPLETION DF CAUSE
									_ /				DF DEATH?
				UCE AT T	A 211				_ Pa	artia	1		1 PYES 2 NO
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	DID TOBACCO US	SE CONTI	RIBUTE TO CA	OUL OI DI			Ar one)				-		
	25. WAS CASE REFERRED TO				ACE OF DEAT	H (Check on	ny oriej						
	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:	26. PL		OTHER:		v					
	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:	26. PL ER/Outpatient	3 🗆 DOA	OTHER:	g Home	5 Residence	6 Other (Spe	ecify)			
	25. WAS CASE REFERRED TO EXAMINER? XXYES 2 NO 27. MANNER OF DEATH		HOSPITAL: 1 Inpatient 2	26, PL ER/Outpatient INJURY	3 DOA	OTHER: 4 Numin	g Home 8c. INJUR	Y AT	6 Other (Spe		URY OCC	URED	
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? XXYES 2 NO 27. MANNER OF DEATH 1 Netural 5 F	MEDICAL	HOSPITAL:	26, PL ER/Outpatient INJURY	3 DOA	OTHER: 4 Nursin	g Home 8c. INJUR WORK	IY AT			URY OCC	URED	
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BY PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? 27. MANNER OF DEATH 1 Netural 5 F 2 Accident II 3 Suicide 6 C	Pending nvestigation	HOSPITAL: 1 Inpetient 2 Inpeti	26, PL ER/Outpatient INJURY	3 DOA	OTHER: 4 Number FOF URY M	Bc. INJUR WORK	IY AT	26d. DESCRIE	N (Street and			oute Number,
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BY PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? XXYES 2 NO 27. MANNER OF DEATH 1 Natural 5 F 2 Accident 3 Suicide 6 C 4 Homicide	MEDICAL Pending Investigation Could not be elermined	HOSPITAL: 1 Inpatient 2 2 280. DATE OF (Month, Date Of Land of	ER/Outpatient INJURY by, Year) F INJURY — At atc. (Specify)	3 DOA 26b. TIMI INJ	OTHER: 4 Nursin E OF 20 URY M	eg Home 8c. INJUR WORK 1 YES	IY AT I? S 2 NO	281. LOCATION City or Tow	N (Street and	d Number	or Rural R	oute Number,
BY PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? XXYES 2 NO 27. MANNER OF DEATH 1 Netural 5 F 2 Accident 3 Suicide 6 C 4 Homicide 6 C 29e. CERTIFIER (Check only)	Pending nestigation Could not be letermined	HOSPITAL: 1 Inpatient 2 289. DATE OF (Month, Date of Desire of Des	26. PL ER/Outpatient INJURY y, Year) F INJURY — At atc. (Specify) my knowledge,	3 DOA 29b. TIMI INJ	OTHER: 4 Nursin E OF 20 URY M	eg Home Bc. INJUR WORK 1 YES y, office	Y AT (? S 2 NO	28f. LOCATION City or Tow to the cause(e)	N (Street and wn, Stete)	d Number	or Rural R	
BY PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? XXYES 2 NO 27. MANNER OF DEATH 1 Netural 5 F 2 Accident 3 Suicide 6 C 4 Homicide 6 C 29e. CERTIFIER (Check only)	Pending nestigation Could not be letermined	HOSPITAL: 1 Inpatient 2 289. DATE OF (Month, Date of Desire of Des	26. PL ER/Outpatient INJURY y, Year) F INJURY — At atc. (Specify) my knowledge,	3 DOA 29b. TIMI INJ	OTHER: 4 Nursin E OF 20 URY M	eg Home Bc. INJUR WORK 1 YES y, office	Y AT (? S 2 NO	28f. LOCATION City or Tow to the cause(e)	N (Street and wn, Stete)	d Number	or Rural R	
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COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? XXYES 2 NO 27. MANNER OF DEATH 1 Netural 5 F 2 Accident 3 Suicide 6 C 4 Homicide 6 C 29e. CERTIFIER (Check only)	Pending meetigation Could not be letermined	HOSPITAL: 1 Inpetient 2 Inpetient 2 See DATE OF (Month, Date of Month, Date of See Date of	26. PL ER/Outpatient INJURY y, Year) F INJURY — At atc. (Specify) my knowledge,	3 DOA 29b. TIMI INJ	OTHER: 4 Nursin E OF 20 URY M	eg Home 8c. INJUR WORK 1 YES y, office e, date en	Y AT (? S 2 NO	26d. DESCRIB 26f. LOCATION City or Tow to the cause(s) time, date end	N (Street and wn, State)	d Number	or Rural R	
BE COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? 27. MANNER OF DEATH 1 Natural 5 Flat 2 Accident 3 Suicide 4 Homicide 6 C. Check only one) 2 MEDIC	Pending meetigation Could not be letermined	HOSPITAL: 1 Inpetient 2 Inpetient 2 See DATE OF (Month, Date of Month, Date of See Date of	26. PL ER/Outpatient INJURY y, Year) F INJURY — At atc. (Specify) my knowledge,	3 DOA 29b. TIMI INJ	OTHER: 4 Nursin E OF 20 URY M	eg Home 8c. INJUR WORK 1 YES y, office e, date en	Y AT (7 S 2 NO No place, end due th occurred at the	28f. LOCATION 28f. LOCATION City or You to the cause(e) time, date end	N (Street and wn, State)	or as atate due to the	or Rural A	end menner ee stated. (Month, Day, Year)
BE COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? XXYES 2 NO 27. MANNER OF DEATH 1 Natural 5 F II 2 Accident 3 Suicide 6 C 4 Homicide 299. CERTIFIER (Check only one) 29b. SIGNATURE AND UTILE	Pending meetigation could not be elemined FYINO PHYSI CAL EXAMINE	HOSPITAL: 1 Inpatient 2 289. DATE OF (Month, Date of Month, Date o	26. PL ER/Outpatient INJURY sy, Year) F tNJURY — At atc. (Specify) my knowledge, samination end/	3 DOA 29b. TIMI INJ home, farm, a death occurre or investigation	OTHER: 4 Nursin E OF URY M Reset, factor	eg Home 8c. INJUR WORK 1 YES y, office e, date en	ry AT (?? S 2 NO No No No No No No No No No	28f. LOCATION 28f. LOCATION City or You to the cause(e) time, date end	N (Street and wn, State)	or as atate due to the	or Rural A	end menner ee stated.
BE COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? 27. MANNER OF DEATH 1 Natural 5 Flat 2 Accident 3 Suicide 4 Homicide 6 C. Check only one) 2 MEDIC	Pending meetigation could not be elemined FYINO PHYSI CAL EXAMINE	HOSPITAL: 1 Inpatient 2 289. DATE OF (Month, Date of Month, Date o	26. PL ER/Outpatient INJURY sy, Year) F tNJURY — At atc. (Specify) my knowledge, samination end/	3 DOA 29b. TIMI INJ home, farm, a death occurre or investigation	OTHER: 4 Nursin E OF URY M Reset, factor	eg Home 8c. INJUR WORK 1 YES y, office e, date en	Y AT (7 S 2 NO No place, end due th occurred at the	28f. LOCATION 28f. LOCATION City or You to the cause(e) time, date end	N (Street and wn, State)	or as atate due to the	or Rural A	end menner ee stated. (Month, Day, Year)
BE COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? XXYES 2 NO 27. MANNER OF DEATH 1 Natural 5 F II 2 Accident 3 Suicide 6 C 4 Homicide 299. CERTIFIER (Check only one) 29b. SIGNATURE AND UTILE	Pending meetigation could not be elemined FYINO PHYSI CAL EXAMINE	HOSPITAL: 1 Inpatient 2 289. DATE OF (Month, Date of Month, Date o	26. PL ER/Outpatient INJURY by, Year) FINJURY — At etc. (Specify) my knowledge, samination end/	3 DOA 29b. TIMI INJ home, farm, s death occurre or investigatio	OTHER: 4 Nursin End of the limit On in my opin Print)	eg Home 8c. INJUR WORK 1 YES y, office e, date en nion, deat	AY AT 17 S 2 NO Ind place, end due th occurred at the 9c. LICENSE NUR	28f. LOCATION City or You to the cause(e) time, date end ABER	N (Street and wn, Stete)	or as atate due to the	or Rural R	end menner es stated. (Month, Day, Year)
TO BE COMPLETED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO EXAMINER? XXYES 2 NO 27. MANNER OF DEATH 1 Natural 5 F II 2 Accident 3 Suicide 6 C 4 Homicide 299. CERTIFIER (Check only one) 29b. SIGNATURE AND UTILE	Pending Investigation Could not be letermined FYINO PHYSI CAL EXAMINE OF CERTIFIER PERSON WHI	HOSPITAL: 1 inpatient 2 28e. DATE OF (Month, Dr. 28e. PLACE OI building, CIAN: To the best of R: On the besie of sy	26. PL ER/Outpatient INJURY by, Year) FINJURY — At etc. (Specify) my knowledge, samination end/	3 DOA 29b. TIMI 29b. TIMI NJ home, farm, s death occurre or investigation	OTHER: 4 Nursin End of the limit On in my opin Print)	eg Home 8c. INJUR WORK 1 YES y, office e, date en nion, deat	AY AT 17 S 2 NO Ind place, end due th occurred at the 9c. LICENSE NUR	28f. LOCATION City or You to the cause(e) time, date end ABER	N (Street and wn, Stete)	or as atate due to the	or Rural R	end menner ee stated. (Month, Day, Year)
BE COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? 27. MANNER OF DEATH 1 Netural 5 F 2 Accident 3 Suicide 4 Homicide 6 C 29e. CERTIFIER (Check only one) 2 MEDIC 29b. SIGNATURE AND LITTLE 1 30. NAME AND ADDRESS OF DATA	Pending Investigation Could not be letermined FYINO PHYSI CAL EXAMINE OF CERTIFIER PERSON WHI	HOSPITAL: 1 inpatient 2 28e. DATE OF (Month, Dr. 28e. PLACE OI building, CIAN: To the best of R: On the besie of sy	26. PL ER/Outpatient INJURY by, Year) FINJURY — At etc. (Specify) my knowledge, carnination end/	3 DOA 29b. TIMI 29b. TIMI NJ home, farm, s death occurre or investigation	OTHER: 4 Nursin End of the limit On in my opin Print)	eg Home 8c. INJUR WORK 1 YES y, office e, date en nion, deat	AY AT 17 S 2 NO Ind place, end due th occurred at the 9c. LICENSE NUR	28f. LOCATION City or You to the cause(e) time, date end ABER	N (Street and wn, Stete)	or as atate due to the	or Rural R	end menner ee stated. (Month, Day, Year)



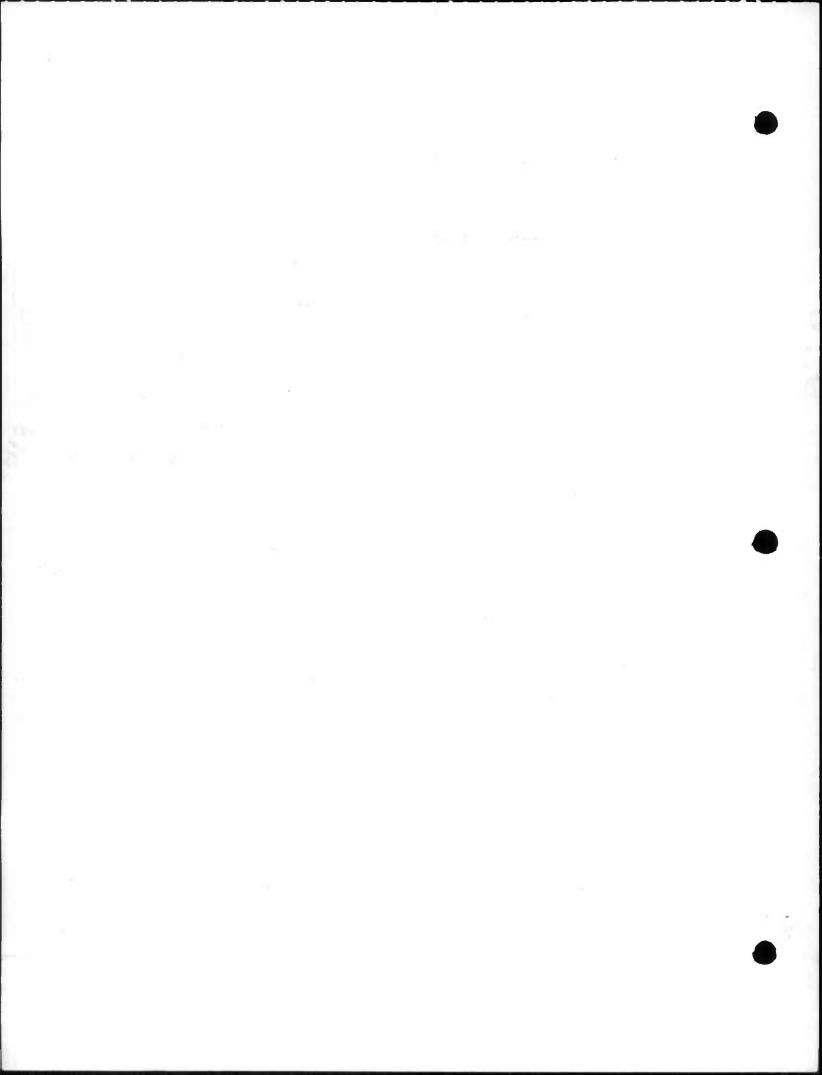
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 54 hours after death. Page 6 may be retained by the hospital or attending physician and competely filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

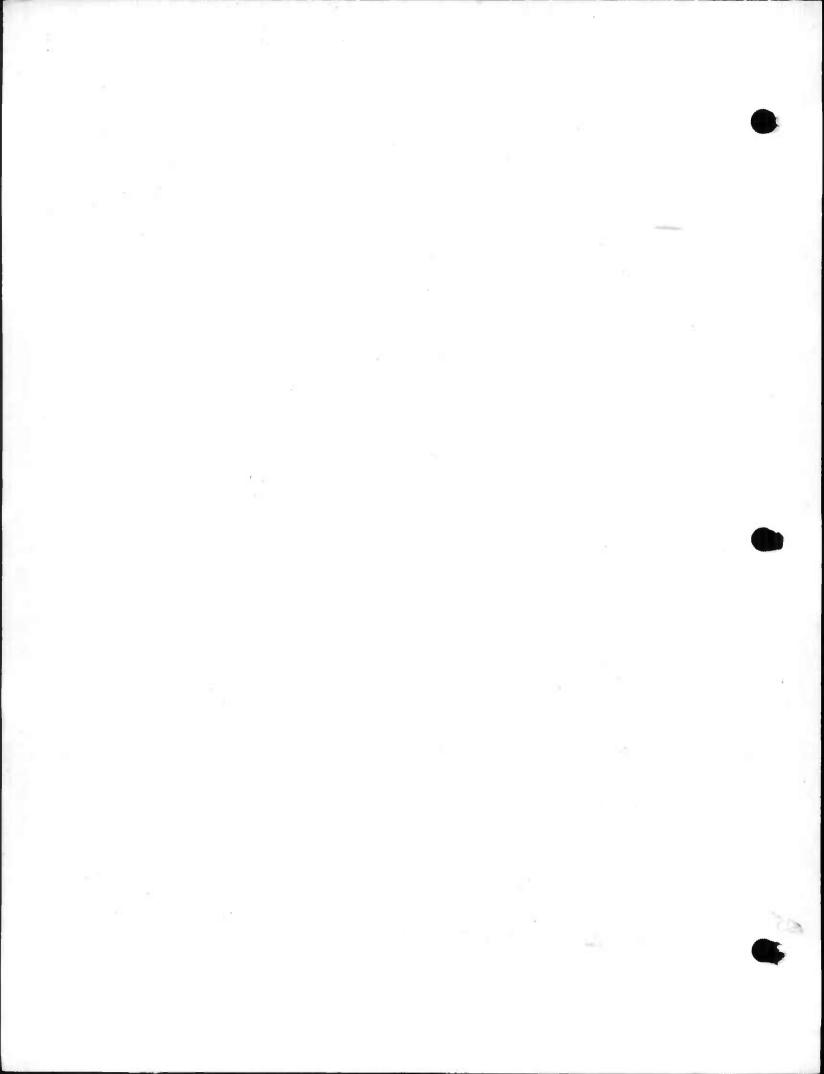
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	TATE OF MARYLAND / DEPARTM	IENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)		THE OF BEATTI	2. DATE OF DEATH	3. TIME OF DEATH			
	BEENARD	HABER		FEBRUARY 14. 1	995 11:55 A M			
	4. SOCIAL SECURITY NUMBER 5. SI	EX 8. AGE (In yrs. last birthday) IF	UNDER 1 YEAR IF UNDER 24 HRS.	7. OATE OF BIRTH	8. BIRTHPLACE (State or Foreign			
	219-56-3228 XX	M 2 □ F 45 YRS. MO	VTHS DAYS HOURE MIN.	Feb 9, 1950	Maryland			
~	9e. FACILITY NAME (If not institution, give street an	od number) 96	CITY, TOWN OR LOCATION OF DE	EATH 9c. COUN	TY OF OEATH			
DIRECTOR	THE JOHNS HOPKINS H	OSPITAL B	ALTIMORE CITY					
E C	10e. STATE 10b. COUNTY		OWN OR LOCATION		10d. INSIDE CITY			
	Maryland Baltin	more County Bal	ltimore		1 TYES 2 X NO			
AL	10e. STREET AND NUMBER		101. ZIP CODE	10g. CITIZ	EN OF WHAT COUNTRY?			
FUNERAL	51 Lerner Court		21236		USA			
F	11, MARITAL STATUS . 12. V	MAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO FYES, GIVE WAR OR DATES	If yes, specify Cuben, Mexico	in, Puerto Ricen, atc.)	14. RACE — American Indian, Black, White, etc.			
BY	3 Widowed 4 Divorced	r yes, give war or dates Vietnam Era	1 YES NO Specif	y:	Specify: White			
ED	15. DECEDENT'S EDUCATION (Specify only highest grade comple	18a. DECEDENT'S USU	IAL OCCUPATION	16b. KIND OF BUSINESS/INDU	JSTRY			
COMPLET		lege (t-4 or 5+) life. Do NOT use ret	done during most of working tired.)		(1)			
MP	12 years	Supervis	sor	Direct Mai	1			
	17. FATHER'S NAME (First, Middle, Last)			ME (First, Middle, Maiden Surname)				
BE	Bernard John Haber		Sarah					
2	Robert E. Lilley			Balto., MD 2123				
	20e. METHOD OF DISPOSITION	20h PLACEAND DATE OF DE		DATE 20c. LOCATION - C				
	1 Donation 8 Other (Specify)	cemetery, crematory or other p		2/16 Baltimore				
	21. SIGNATURE OF FUNERAL SERVICE LICENSES		22. NAME AND ADDRESS OF FA	CILITY	, nary tand			
	Martin D. Lawson	1	Mitchell-Wied	defeld Home ad, Baltimore, 1	vm 21212			
	23. PART i. Enter the diseeses, or compli	icetions that caused the deeth. Do not			et, Approximete			
	shock, or heart fellure. List D IMMEDIATE CAUSE (Finel	nly one cause on each line.			Interval Between Onset and Daeth			
	disesse or condition resulting in death)	SEPSIS			lodaus			
	DUE TO (OR AS A CONSEQUENCE OF):							
N O	Sequentisity list conditions,	DEDUCTOR PLURAL DUE TO (OR AS A CONSEQUENCE OF):	- FISTULA		14 days			
ATI	if any, leading to immediata cause. Enter UNDERLYING	Risht lower 1	she relact	841	15 days			
띮	CAUSE (Diseese or Injury that Initiated evants	DUE-TO (OR AS A CONSEQUENCE OF):	BI-CI CARMO	or o	100174			
CERTIFICATION	resulting in death) LAST	Ischemic CARI	210 MYORAT	4-1	IUR			
	PART ii. Other significent conditions con	tributing to death but not requiting in the	ne underluing cause given in	/	Last were surrous engines			
CAL	acute renal.	failure, theon	lease to not the	PERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE			
G	Hus anage	1 100000	10000	1 YES 2 NO	OF DEATH?			
₹.		TE TO CAUSE OF DEATH YES	□ NO □ UNCERTAII	N I	1 TYES 2 X NO			
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEATH (C						
SIC			HER: Nursing Home 5 - Residence	8 Other (Specify)				
H		28e, DATE OF INJURY (Month, Day, Year) 28b, TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCC	UREO			
B	1 Natural 5 Pending Investigation		M t YES 2 NO					
	3 Suicide 8 Could not be 4 Homicide determined	 PLACE OF INJURY — At home, ferm, street building, atc. (Specify) 	t, factory, office	28f. LOCATION (Street and Number of City or Town, State)	or Rural Route Number,			
COMPLETED	20. CESTIFIED							
MPI	(Check only	To the beat of my knowledge, death occurred at						
8		the besis of examination end/or investigation, in			ceuse(s) end menner es stated.			
BE	29b. SIGNATURE AND TITLE OF CERTIFIED	7 1 4 .	29c. LICENSE NUI	MBER 29d. DATE	SIGNED (Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO COM	PLETED CAUSE OF DEATH (ITEM 27) (Type Prin	1-104	1 2	/14/45			
	KRIS JEN	NER SURCE		DENT JOHN.	Makey Headle			
		32 DEGISTRAR'S CHAPURE	G-/ (Cest	DEIO! JENO!	MOLIUM NOW			
	LED 1 6 1992	CO-ILLIANDER PARTIES						



			FOR 1 - STATE REGISTRAR	STATE OF MAI	RYLAND	/ DEPART	MENT O	F H	EALTH AND	MENTA	L HYGIEI			
			1. DECEDENT'S NAME (First, Middle, Last)				,,,,,		DEATH	2. DATE	OF DEATH		3.	TIME OF DEATH
	•		Harriet Elizabe	th	Hurst					Febr	uarv]	DAY 1 199	YEAR	915 PM
			4. SOCIAL SECURITY NUMBER		AGE (In yrs. le		IF UNDER 1 YE	EAR AYS	IF UNDER 24 HRS.	7. DATE	OF BIRTH h, Day, Year)	(Country)	ACE (State or Foreign
215-	24 ₌ 8643		215-24-8643	1 M 2 V F	68	YRS.	ONTHS DA	ATS	HOURS MIN.			926	Maryla	and
	2, 3 shou	стов	9a. FACILITY NAME (If not institution, give so Stella Maris Hospice RESIDENCE OF DECEMENT			1	TOWS		R LOCATION OF D	EATH			y of deat	Н
	-	ᇤ	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c CITY	TOWN OR L		ION .			, Dare		4 INDIOS OLTY
	permit. Pages	DIRE	325 Maryland N/			loc. Giri,	Balti	mon	e				1)	d. INSIDE CITY LIMITS? XX YES 2 NO
		FUNERAL	100. STREET AND NUMBER 325 Homeland S	outhuny				101.	21212					T COUNTRY?
0	priysician. burfal-transit	3	11. MARITAL STATUS	12. WAS DECEDENT EV			13. WAS	DECE	ENDENT OF HISPA	NIC ORIGI	N? (Specify Ye		ISA 4. race —	American Indien,
5-0020	a a	В	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 [] IF YES, GIVE WAR		NO	If yo	YES	cify Cuban, Maxic 2 XXNO Spec		Rican, atc.)		Specify:	White
121	use as	E	ts. DECEDENT'S EDU (Specify only highest grade	CATION completed)		ECEDENT'S US	rk done durin	PATIO	N at of working	161	, KIND OF BU	JSINESS/INDU	STRY	
MARYLAND 21	ed for	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)		ict and	,	nal			Educa	ation		
AN	detached once.	NO.	17. FATHER'S NAME (First, Middle, Last)	<u>:</u>	LASS	istant	STIRL	par	16. MOTHER'S N	AME (First,				
3YL	d be	BE 0	Hiram Springer Hurst						Carolyn	Joser	hine De	enhard		
MARYLAN	5 should notified	0	19a. INFORMANT'S NAME (Type/Print)						nd Number or Rura	Route Num	ber, City or To	wn, State, Zip C	ode)	
			C. D. Flagle			1822 Ci					-			
OR	ector, p		1 Burlal 2 XXCremation 3 Remarks Donation 5 Other (Specify)	oval from State	cemetery, ci	mount C	r place)	Y"\	na or	2/13		ocation — ci ltimore,		
M I	funeral director,	l V	21. SIGNATURE OF FUNERAL SERVICE LIC		<u> urca</u>	induit o			D ADDRESS OF F	ACILITY				turio
BALTIMORE,	the funeral dir oval.		Martin &	suson			65	00	York Road	Balti	imore, M	feld Hom Maryland	21212	2
100	ed in b		23. PART I. Enter the diseases, or cahock, or heart failure.	emplications that ca list only one cause	oused the d	eath. Do no	t enter the	e mod	de of dying, su	ch ss car	disc or resp	oiretory srre	ıt,	Approximate interval Between
	B 9 B		IMMEDIATE CAUSE (Final disease or condition	CARCII	Mon	AOF	1	اما	6					Onset and Death
60,	completely fille ial, cremation, event, the		resulting in death)	DUE TO (OR	AS A CONSI	EOUENCE OF):		/1 4						01103.
(68760,		N	Sequentially list conditions,	o										
X	cian or 1	CATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR	AS A CONSE	OUENCE OF):								
B	or phy	RTIFIC	CAUSE (Disease or Injury that initiated eventa	DUE TO (OR	AS A CONSE	OUENCE OF):								
P.0	5 5	ERT	resulting in death) LAST	1.										
DS, P		L C	PART II. Other significant condition	s contributing to der	ath but not	resulting in	the under	rivina	cause given in	Part I.	24a, WAS A	N AUTOPSY	24h. W/	RE AUTOPSY FINDINGS
	signed by Health and	EDICA	BONE MET	MSTASE							PERFO	RMED?	AW/	AILABLE PRIOR TO IMPLETION OF CAUSE
RECOR	been signed by t. of Health and shows any	MED								_	1 🗆 123	2 0 110		DEATH?
		AN:												
Y A	a se E	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			THER:	26. PL/	ACE OF DEATH (C	heck only o	ne)			
OF VI	the the	> II	1 YES 2 NO	1 Inpatient 2 ER		3 DOA 6	Nursing		5 Residenca	Y		IN HIPV COCH	DED	
1 OF	this with	Y PH	Natural 5 Pending	(Month, Day, Y	Year)	INJUR	KA.	WOF	ES 2 NO	260. DE	SCHIBE HOW	INJURY OCCU	NED.	
VISION	R. After r death is ma	D BY	3 Suicide 6 Could not be	28e. PLACE OF IN building, atc.	(Specify)	ome, ferm, str	eet, fectory,	office		281. LOC	ATION (Street or Town, State	and Number of	Rural Rout	e Number,
DIVISION	DIRECTOR: After hours after death tem 28 is ma	ETE	4 Homicide determined		10000077					J.	or rown, State	"		
5	3 - 7 7 - 1			CIAN: To the best of my										121
Tur uocoitai	TO THE FUNERAL De filed within 72 IMPORTANT: If	COMPL	000) 2 MEDICAL EXAMINE	R: On the besis of exami	Ination and/or	Investigation,	In my opini	lon, de	ath occured at th	e time, data	and placa, a	nd due to the	cause(s) an	d manner as stated.
יים ביים	ORT	BE	29b. SIGNATURE AND TITLE OF CERTIFIER	C 000					29c. LICENSE NU	IMBER		29d. DATE :	SIGNED (MC	onth, Day, Year)
٤	2 6 8 X	5	30. NAME AND ADDRESS OF PERSON WH	COMPLETED CAUSE	LIM DE DEATH (17	FM 271 / F 7	rint)		日本文	243		10	113/	45
<			KR Faulkner mi	2/2300	Dula		alles	R	2d/Ba	0+10	nore	MD	2	1204
-			FEB 1 6 1905	32 ABEGISTRAR'S	GNAYURE	0	C)						
100		- 1	()											





DIVISION OF VITAL RECORDS, P.O. BOX 68760

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31. DATE FILED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. JEGISTRAR'S SIGNATURE

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ANGELIA HAMILTON K OUQUEZ 6:55 FEB 14 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYE 1 M 2 YF 441-94-8538 April 1, 1972 Arkansas Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH UNIVERSITY S.T.U. BALTIMORE CITY DIRECTOR RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Prince George's permit. Laurel 1 YES ZY NO FUNERAL 10e. STREET AND NUMBER 10f. 7IP CODE 10g. CITIZEN OF WHAT COUNTRY? 13623 Avebury Drive, Apt. 14 use as the burial-transit 20708 USA hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 NO 1 Never Merried 2 X Merried BY Specify: 3 Widowed 4 Divorced white ED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe COMPLET the funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) 12 1 Sales Rep Cellular Phone Company 17. FATHER'S NAME (First Middle (ast) 18. MOTHER'S NAME (First, Middle, Malden Surname) Calvin Earl Teague 듆 Sharon Kouquez Cowan notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Brandon Hamilton 13623 Avebury Drive, Apt. 14, Laurel. Md. 20708 9 20e. METHOD OF DISPOSITION

X Burlel 2 Cremation 3 Rem

4 Donation 6 Other (Specify) PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION Gans must Gans Cemetery 2/20 NE Sallisaw, OK AKITIS TOME LEL 21. SIGNATURE OF FUNERAL BERVICE LICENSEE, examiner 22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman - Funeral Home of Elk., Inc 23. PART I. Enter the diseases or complications that caused the death. Do not anter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. medical signed by the attending physician and completely filled in by Health and Mental Hygiene prior to burial, cremation, or remo Approximsta Interval Batween IMMEDIATE CAUSE (Final Onset end Death the disesse or condition resulting in death) Multiple Gunshot Wounds event. DUE TO (OR AS A CONSEQUENCE OF) executed traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if eny, lesding to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 any injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 ☐ YES 2 ☐ NO Shows 1 YES 2 NO has been a DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: WE 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The Item certificate h **EXAMINER?** L DR ATTENDING PHYSICIAN: Th L DIRECTOR: After this certificate hours after death with the State HOSPITAL: 1 X YES 2 NO npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 26e. DATE OF INJURY 26b. TIME OF INJURY 28c. INJURY AT WORK?

1 YES 2 NO 26d, DESCRIBE HOW INJURY OCCURED marked, 1 Netural 5 Pending BY 1200 2 Accident Investigation 261. LOCATION (Street and Number or Purel Route Number, City or Town, State) Ethyl Dr. 1. Old Annagel of Laurel 40 26e, PLACE OF INJURY - At he 3 Sulcide me, ferm, streef, factory, office 69 ETED. 6 Could not be 4 MHomicide builden 28 tem 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred by the time, date end place, end due to the ceuse(e) end manner ee stated COMPL FUNERAL (
within 72 h HOSPITAL MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occured at the films, date end place, end due to the cause(e) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 29b. SIGNATURE AND THE OF CERTIFIER

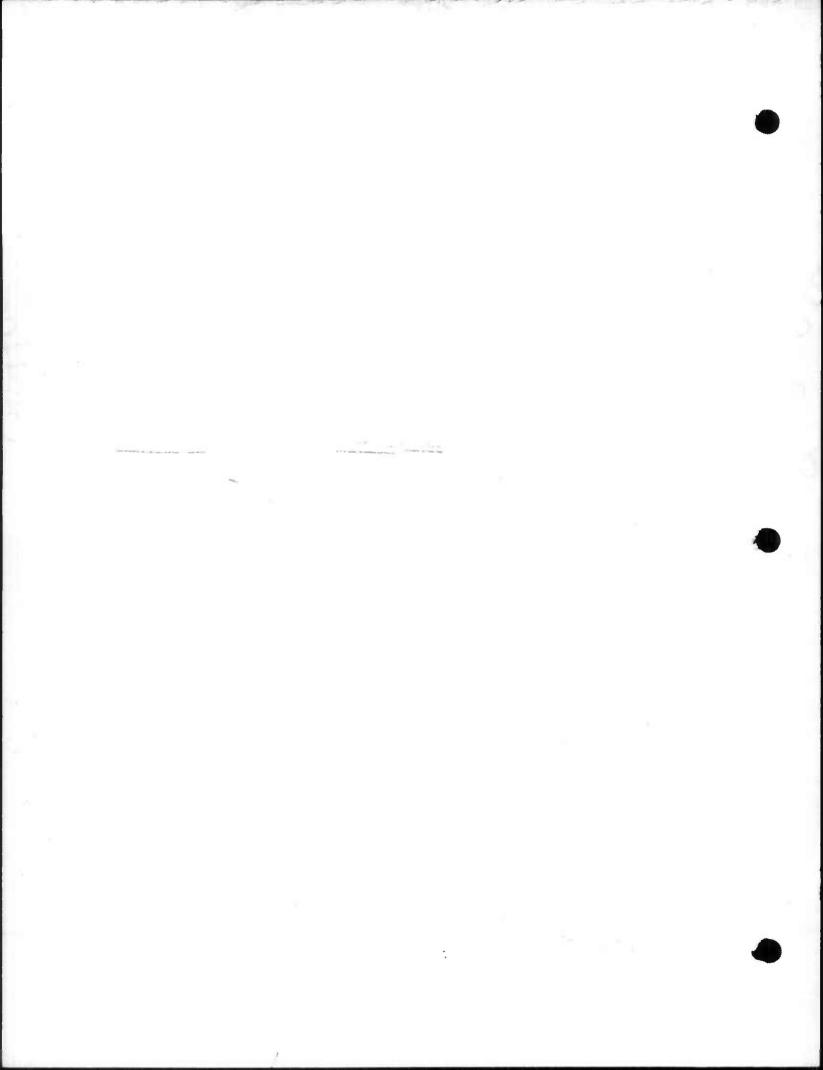
29c. LICENSE NUMBER

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d, DATE SIGNED (Month, Day, Year)

FEB 15, 1995



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PHYSICIAN:

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COMPLET

BE

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3 Suicide

4 Homicide

29a. CERTIFIER

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Pages 1, 2, 3

permit.

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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled it	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the m
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	AN	tific	S	-
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95 04884 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 10/95 3. TIME OF OEATH COLETHIA HAYES, JR. 1:30 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 2716765 1 💢 M 2 🗌 F Hyattsville, Md 578-82-1687 29 YRS 9a. FACILITY NAME (If not institution, give street and number, 9b, CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR Hyattsville Manor Nursing Home Hyattsville, Md. P.G. RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 X YES 2 NO Washington 10a STREET AND NUMBER FUNERAL 10g, CITIZEN OF WHAT COUNTRY? U.S.A. 1624 Rosedale Street, N.E. 20002 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-th ves. specify Cuben, Maxican, Puerto Ricen, stc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 2 XNO If yes, specify Cuben, Maxicon, Puerto Ri 1 YES 2 X NO Specify: ВУ Specify: Black 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEOENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Randall Senior Citizens 10th Attendant 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Coble Hayes Colethia Hayes, Sr. BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1624 Rosedale Street, N.E., Washington, D.C. 20002 Dorothy Coble 20a. METHOD OF DISPOSITION

1 X Buriat 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata DATE Donation 5 Other (Size Glenwood Cemetery 2/14/95 Washington, D.C. 22. NAME AND ADDRESS OF FACILITY ROBERT G. Mason Funeral Home, Inc. #866 1661 Good Hope Road, S.E., DC 20020 wh. Do not enter the mode of dying, such as cerdiac or respiratory arrest, dations that car ck for heart fal Interval Between IMMEDIATE CAUSE (Final Onset and Death ACQUIRED IMMUNE DEFICIENCY SYNDROME disease or condition UNKNOWN resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 37 NO

1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES EX NO [

25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. MANNER OF QEATH 28b. TIME OF INJURY

28a, DATE OF INJURY 1 Natural 5 Pending 2 Accident

Investigation 28a. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 8 Could not be detarmined

And troute 2 - treatments	o 🗆 Other (apecity)
28c. INJURY AT WORK?	26d. DESCRIBE HOW INJURY OCCURED
1 YES 2 NO	

1 🖎 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause	-(-)

NATURE AND TITLE

29c. LICENSE NUMBER D01499

29d. DATE SIGNED (Month, Day, Yes ar 13

20740

281. LOCATION (Street and Number or Rural Floute Number, City or Town, State)

DR. LEWIS HILLIARD DENNIS 6201 Greenbelt Rd. #U-1 College Park, MD 31. DATE FILED (Morith, Day, Year)

32. REGISTRAR'S SIGNATURE

print a life of the residence

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

BALTIMORE, MARYLAND 21215-0020

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

ITEMS 23 PART I, 27, PER MED FILM G- 720 2/16/95 t.t.

	1 - STATE REGISTRAR	STATE OF MAR	RYLAND / DEPAF CERTIF	ICATE	OF HEALT	H AND	MENT	AL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last) CALVIN	Ε.	I	IALE			MON	E OF DEATH	AY	YEAR 95	3. TIME OF DEATN 10:35A M
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. lest birthday)	IF UNDER 1		DER 24 HRS.	7. DAT	N. E OF BIRTH		6. BIRTN	PLACE (State or Foreign
	214-44-8084		4.7 YRS.	MONTHS	DAYS HOUR	B MIH.		nth, Day, Year) — 4.7		Country	YLAND
œ	9e. FACILITY NAME (If not institution, give				OWN OR LOCA		EATN		9c. COUN		
DT:	2342 BARCLAY	STREET		BA	LTIMO	JKE (
DIRECTOR	10e. STATE 10b. COUNT	TY .	10c. CIT	Y, TOWN OR	LOCATION						10d. INSIDE CITY LIMITS?
	MARYLAND										1 YES 2 NO
RAI	10e. STREET AND NUMBER				10f. ZIP CO				10g. CITIZ	EN OF W	HAT COUNTRY?
FUNERAL	2342 BARCLAY S	12. WAS DECEDENT EV	ER IN U.S. ARMED	13 WA	212		NIC OBIG	IN? (Specify Ye	U		Anadan India
В	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 1 IF YES, GIVE WAR	YES 2 X NO	If y	es, specify Cu	ben, Mexic	en, Puerto	Rican, etc.)	or No.	Specif	— American Indian, , White, etc. y: A C K
	15. DECEDENT'S EDU (Specify only highest grade	JCATION completed)	18s. DECEDENT'S (Give kind of	work done dur	UPATION ing most of wo	rkina	16	b. KIND OF BU	SINESS/INDI	80° AU A	1010
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	life, Do NOT u								
COMPLETED	17. FATNER'S NAME (First, Middle, Last)		L CARIN	ET M		OTHER'S NA	ME (First.	Middle, Malden	Sumamal		
BE C	PRESTON SIMMS					TTIE			,		
10	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (S				nber, City or Tow	n, State, Zip	Code)	
	KATHLEEN BARKS	DALE				TTE					E. MARYLAND
	1 Buriel 2 Cremetion 3 Ren	noval from State	cometery, crematory or o	ther place)			DA		CATION — C		vn, Stete
	21. SIGNATURE OF FUNEHAL SERVICE L	PENSEE 0 1	MT ZIO		1 - 26 - ME AND ADDI	95 PESS OF FA	CILITY	IBAL	TIMO	RE	
	1 /20 (null									
	23. PART I. Enter the dieceses, or	complications that ce	used the death. Do r	not enter th	e mode of c	tying, suc	ORT h se ce	H AVE	NUE ratory erre	eat,	Approximate
	shock, or heart fellure. IMMEDIATE CAUSE (Finel	Liet only one ceuse of	on each line.								Interval Between Onset and Death
	disease or condition resulting in desth)	e. FATTY I									
		DUE TO (OR	AS A CONSEQUENCE OF	F):							
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	bDUE TO (DR	AS A CONSEQUENCE O	F):							
CA	ceuse. Enter UNDERLYING CAUSE (Diseese or injury	c									
	that initiated events resulting in death) LAST	DUE TO (OR	AS A CONSEQUENCE OF	F):							
CEF		d									
CAL	PART II. Other significant condition	ne contributing to dee	th but not reculting	In the unde	rlying ceuse	given in	Part I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
								1 X YES 2	□ NO		COMPLETION OF CAUSE OF DEATH?
Σ.	DID TOBACCO USE CONT	DIBLITE TO CALIC	E OF DEATH VI	'C [] N/	2 [7] (18)	CEDTAL					1 TES 2 NO
NA I	25. WAS CASE REFERRED TO MEDICAL	KIBOTE TO CAUSI	26. PLACE OF DEAT			ICERTAI	ΝЦ				
PHYSICIAN: MED	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/	Outpetient 3 DOA	OTHER:	Home 5X	Residence	6 🗆 Oth	er (Specify)			
E	27. MANNER OF DEATH	28e. DATE OF INJU (Month, Day, Ye			Ic. INJURY AT WORK?			SCRIBE HOW I	NJURY OCCI	URED	
B	1)(X) Natural 5 Pending 2 Accident Investigation				YES 2	□ NO					
ETED	3 Suicide a Could not be 4 Homicide determined	26e. PLACE OF INJ building, etc. (JURY — At home, ferm, a (Specify)	kreet, fectory	, office		2at. LO	CATION (Street e r or Town, State)	and Number o	or Rural R	oute Number,
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYS 2 MEDICAL EXAMINE	ER. On the basis of market	nowledge, death occurrention and/or investigation								end meriner se stated.
ш	296 SIGNATURE AND TITLE OF CENTINE	*01x h			29c. LI	CENSE NU	MBER		29d, DATE	SIGNED	Month, Day, Yeer)
10 B	myry	all A	N		0.	.C.M	.E.		▶ J	AN.	30/95
- 4	MARIO F CIONU	GAR AKE	F DEATH (ITEM 27) (Type, 1111 Penn		eet,	Balt	imo	re, Ma	aryla	nd	21201
	FEB 1 6 1995	12. REGISTRAR'S S	SIGNATURE AND AND AND AND AND AND AND AND AND AND								

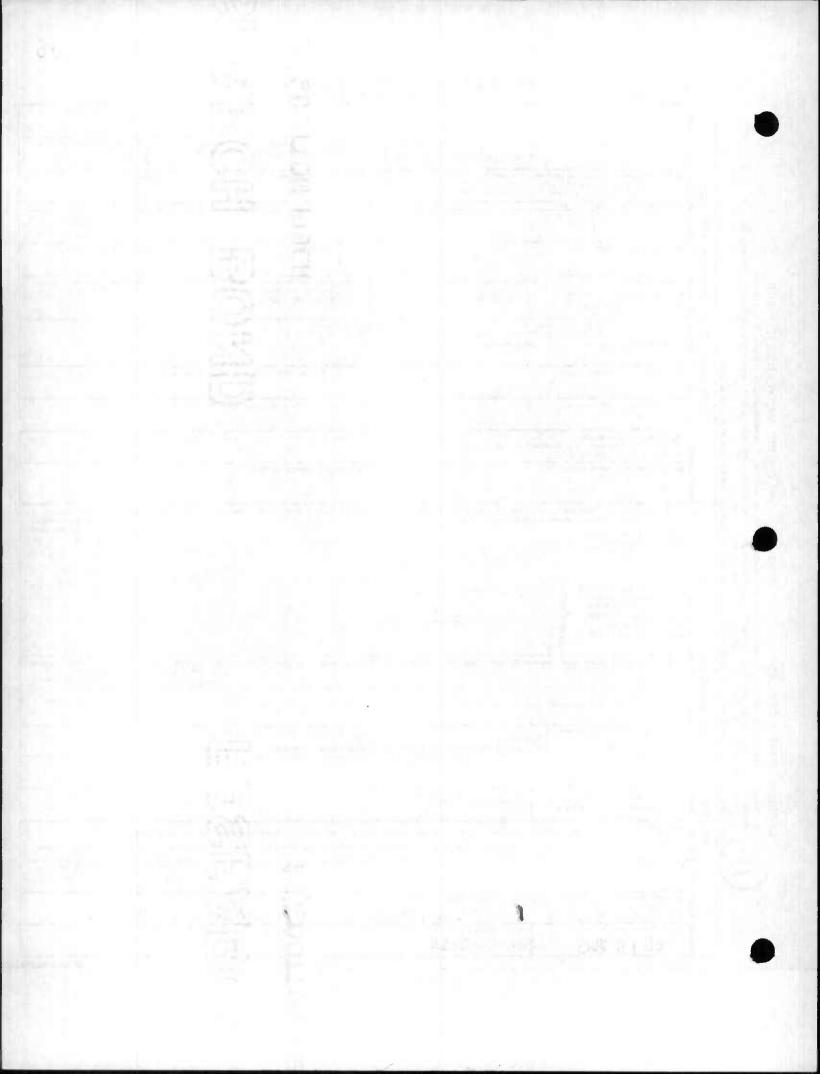
BALTIMORE, MARYLAND 21215-0020	LOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the course after death. Page 6 may be retained by the hospital or attending physicia	
8	after d	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	w requires that the death certificate be executed within	
VISION OF VITAL	ATTENDING PHYSICIAN: The law	

COSTING PHYSICIAN: The law requires that the death certificate be executed within a flour death. Page 6 may be retained by the retained by the the post of the activities has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should not a ster death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

APPLIFIED 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT	OF HEALTH AND ME	NTAL HYGIEN
CERTIFICATI	OF DEATH	REG. NO.

CARRIE B. HAMILTON **SOCIAL SCURITY NUMBER** **SOCIAL SCURITY NAME or of semantic part of
NORTH ARUNDEL HOSPITAL ASSOCIATION GLEN BURNIE 104. CETY, TOWN OR LOCATION 105. STREET ADMINISHER 105. COOKINTY 105. STREET ADMINISHER 105. COOKINTY 105. STREET ADMINISHER 105. COOKINTY 105. STREET ADMINISHER 105. COOKINTY 105. STREET AND NUMBER 105. STREET A
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T. FATHER'S NAME (First, Models, Lavi) COCICE Washington Phelps 19. MOTHER'S NAME (First, Models, Lavi) Caroline Weaver Caroline Weaver Caroline Weaver 19. MARING ADDRESS (Street and Number of Part Robust Number, Cay or Name, Shan, 2p Code) Ponna Rogers 20. METHOD OF DISPOSITION 19. MARING ADDRESS (Street and Number, Cay or Name, Shan, 2p Code) 590 Duvall Highway, Passadena, MD 21122 20. METHOD OF DISPOSITION 19. Maring Part (Party Number) 21. SIGNATURE OF CHARMS (Final disease). A Removal from State 22. SHANTIL Enter the diseases, or complications that caused the deeth. Do not enter the mode of sying, such as cardiac or respiratory street, interest and shand, or heart failure. List only one cause on sach line. 19. MARING ADDRESS (Final diseases or complications that caused the deeth. Do not enter the mode of sying, such as cardiac or respiratory street, interest and shand. Or heart failure. List only one cause on sach line. 19. MARING ADDRESS (Final diseases or complications that caused the deeth. Do not enter the mode of sying, such as cardiac or respiratory street, interest and shand. Or heart failure. List only one cause on sach line. 19. MARING ADDRESS (Final diseases or complications that caused the deeth. Do not enter the mode of sying, such as cardiac or respiratory street, interest and shand. The sach line of sach line. 20. MARING ADDRESS (Final diseases or complications that cause on sach line. 19. MARING ADDRESS (Final diseases or complications that cause on sach line. 20. Policy (Final diseases or complications) 21. Approximate interest and shand. Approximate interest and shand. The sach line of sying, such as cardiac or respiratory street, interest and shand. The sach line of sying in deeth. 22. Maring Address or final failure. List only one cause on sach line. 23. MARING ADDRESS of PERSON MINIOCOMPACT To the best of my knowledge, death occurred at the time, date and place, and due to the cause(g) and manner as stated. 23. MARING ADDRESS of PERSON WIN COMPACT TO SAUSE OF DEA
The Antimeter Programmer State (Special Name (Properties) 196. MAKING ADDRESS (Sines and Number of Paul Runnick City or Town, State 2 Code) 196. MAKING ADDRESS (Sines and Number of Paul Runnick City or Town, State 2 Code) 196. MAKING ADDRESS (Sines and Number of Paul Runnick City or Town, State 2 Code) 196. MAKING ADDRESS (Sines and Number of Paul Runnick City or Town, State 2 Code) 197. Burst 2 Commission of Department of Code (Paul Runnick) 208. PARCE AND DATE CODE (Special Runnick) 208. PARCE AND DATE CODE (Special Runnick) 21. SHOWLING CE SUMPERAL SERVICE LICE (Special Runnick) 22. AMAKE AND ADDRESS OF PRESIDENT (Paul Runnick) 22. AMAKE AND ADDRESS OF PRESIDENT (Paul Runnick) 23. PART II. Other algorificant conditions 24. ADDRESS (Place Code) 25. AND CALL Service Code (Paul Runnick) 26. ADDRESS (Place Code) 27. MANNER OF DEATH (Chock only code) 28. AND CALE RETERIES TO MEDICAL PROPRIES (Place Code) 29. MANNER OF DEATH (Chock only code) 29. MANNER OF DEATH (Chock only code) 29. MANNER OF DEATH (Chock only code) 29. MANNER OF DEATH (Chock only code) 29. MANNER OF DEATH (Chock only code) 29. MANNER OF DEATH (Chock only code) 29. MANNER OF DEATH (Chock only code) 29. MANNER OF DEATH (Chock only code) 29. MANNER OF DEATH (Chock only code) 29. MANNER OF DEATH (Chock only code) 20. MANNER OF DEATH (Chock only code) 20. MANNER OF DEATH (Chock only code) 20. MANNER OF DEATH (Chock only code) 20. MANNER OF DEATH (Chock only code) 20. MANNER OF DEATH (Chock only code) 20. MANNER OF DEATH (Chock only code) 20. MANNER OF DEATH (Chock only code) 20. MANNER OF DEATH (Chock only code) 20. MANNER OF DEATH (Chock only code) 21. MANNER OF DEATH (Chock only code) 22. MANNER OF DEATH (Chock only code) 23. MANNER OF DEATH (Chock only code) 24. MANNER OF DEATH (Chock only code) 25. MANNER OF DEATH (Chock only code) 26. MANNER OF DEATH (Chock only code) 27. MANNER OF DEATH (Chock only code) 28. MANNER OF DEATH (Chock only code) 29. MANNER OF DEATH (Chock only code) 20. MANNER OF DEATH (
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4. Secondation of Other (Specify) 21. SIGNATURE OF ENDREAD SERVICE LIGHINGREE 21. SIGNATURE OF ENDREAD SERVICE LIGHINGREE 22. NAME AND ADDRESS OF PRICITY MCCUITY FUNCERAL HOme of Pasadena 3204 McCuntain Road, Pas
22. AME AND ADDRESS OF FACILITY MCCUITY Funeral Home of Pasadena 3204 Mountain Road, Pasadena, MD 21122 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, infarral Balvo Onset and D. A S. MUNTAINE OF PASA A CONSCIUENCE 69; DUE TO (OR AS A CONSCIUENCE 69); DUE TO (OR AS A CONSCIUENCE 69); DUE TO (OR AS A CONSCIUENCE 69); DUE TO (OR AS A CONSCIUENCE 69); DUE TO (OR AS A CONSCIUENCE 69); DUE TO (OR AS A CONSCIUENCE 69); DUE TO (OR AS A CONSCIUENCE 69); DUE TO (OR AS A CONSCIUENCE 69); DUE TO (OR AS A CONSCIUENCE 69); DUE TO (OR AS A CONSCIUENCE 69); DUE TO (OR AS A CONSCIUENCE 69); DUE TO (OR AS A CONSCIUENCE 69); DUE TO (OR AS A CONSCIUENCE 69); DUE TO (OR AS A CONSCIUENCE 69); DUE TO (OR AS A CONSCIUENCE 69); 24a. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 MO DUE TO (OR AS A CONSCIUENCE 69); 1 VES 2 MO DUE TO (OR AS A CONSCIUENCE 69); 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 L'ARGERT 1
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2 Accident Investigation 2 Sulcide Could not be detarmined 26a. PLACE OF INJURY — At home, farm, street, factory, office 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 26a. PLACE OF INJURY — At home, farm, street, factory, office 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 27 City or Town, State) 27 City or Town, State 27 City or Town, State 27 City or Town, State 28 City or T
3 Suicide 4 Could not be detarmined 26e. PLACE OF INJURY — At home, farm, street, factory, office 4 Homicide 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred et the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Dey, Year) 29d. DATE SIGNED (Month, Dey, Year) 29d. DATE SIGNED (Month, Dey, Year) 29d. DATE SIGNED (Month, Dey, Year)
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296. SIGNATURE AND TITLE OF CERTIFIER Signature and title of Certifier Signature Si
Mus 646 MD D3(122 ► 2/12/85- 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
KEVIN J. DOYLE, M.D. I ZOO HOSPITAL DRIVE "201 ICLEN BIRNIE MARY) AND 2101
31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE
DUE TO (OR AS A CONSEQUENCE OF) AST d



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MARY!	5 should notified	TO BE	19a_INFORMANT'S NAME (Type/Print)	10- (RESS (Street	and Number or Rural	Route Numbe			1 1		21239
Щ A	page be	٦	20e. METHOD OF DISPOSITION	Martin 206	PLACE AND DATE OF DIS	SPOSITION		BAJE	Ave 20c. LACAT	10A - City or	/	md	7
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ALT death.	the furieral director, wal.		· flrime I	F. Thomps	son Ja	ma 4	3100 W	Z.H.	west	Ave			
a de	A E 2		23. PART I. Enter the diseases, or c shock, or heart fallure. I	complications that caused List only one cause on ea	i the deeth. Do not e sch line.	nter the mo	ode of dylng, suc	ch es cerdi	c or respiret	ory arrest,		pproxime iterval Be	
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68760, ecuted with		ľ		DUE TO (OR AS A	CONSEQUENCE OF):							-2 0	lays
25	and bur	NOI	Sequentially list conditions, if any, leading to immediate	Acute Cystitis DUE TO (OR AS A CONSEQUENCE OF):							_ 1	wee	ek
BO)		RTIFICATION	ceuse. Enter UNDERLYING CAUSE (Diseese or injury	Diabetes	Mellitus consequence of:	s, (c	linical	L)			У	ears	3
S, P.O. Bodeath certificate	he attending phys Mental Hygierie p jury, or other	E	that initiated events resulting in desth) LAST	1.	CONSECUENCE OF):								
DS, I	d Mental	AL CE	PART II. Other significent conditions	s contributing to death br	ut not resulting in th	e underlyin	a cause given in	Part I.	24a. WAS AN AU	TOPSY 2	4b. WERE A	LITOPSY FIR	MDINGS
ORC s that th	th and	OICA	Hepetic Cir	chosis, Per	netration	Pep	ticulce	or	PERFORME	D?	AVAILAB	LE PRIOR T	то
RECOR	of Healt	YSICIAN: MEDIC							21			S 2 🗌 N	10
TAL I		AN	DID TOBACCO USE CONTR		F DEATH YES L 28. PLACE OF DEATH (C)			ИП					
	certificate h the State I, or item	SIC	EXAMINER? 1 YES 2 NO	HOSPITAL:	ОТ	HER:	ne 5 🗆 Reeldence	6 🗆 Other	Specify)		-		
N OF VI	with	Y PH	27. MANNER DF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	WO	JURY AT DRK? YES 2 NO	28d. DESC	RIBE HOW INJU	RY OCCURED			
DIVISION OR ATTENDING P	after d	ETED 8'	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, etc. (Speci	— At home, larm, street,	lectory, offic		281. LOCAT City or	ION (Street and Town, State)	Number or Run	al Route Nun	nber,	
DIN PITAL OR	걸인도	dk.		CIAN: To the best of my knowledge. On the basis of examination							e(s) and me	nner es sti	sted.
I THE HOSPITAL	THE FLINES	8	96. SIGNATURE AND THE OF CERTIFIER				29c. LICENSE NUI	MBER		d. DATE SIGN	ED (Month,	Day, Year)	
101	289	P	M. Q. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Print)		89230)		2-	14-9.	5	
			Ruby Jean Toil	nio, M.D. o	c/o Maryl		General	Hos	pital				
			31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA									
			0 . 9 1	1001									

ITEMS: 73 PART I. 27. 28a-f. PER MEO FILM G-721 3/3/95 t.t

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH EARL **JOHNSON** FEB. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH March 23, 213-68-3711 1 XM 2 1 32 YRS. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 1513 COLE STREET BALTIMORE CITY RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Md. Baltimore permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE retained by the hospital or attending physician. 5 should be detached for use as the bunal-transit 1513 Cole St. 21223 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED BALTIMORE, MARYLAND 21215-0020 FORCES? 1 V YES 2 If yes, specify Cuben, Mexican, Puerto Ri 2 NO 1 Never Married 2 X Married BY 3 Widowed 4 Divorced 1980 -1983 ED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY ᆸ funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Brick Mason 12 once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Grady Johnson notified at Addie Etheridae BE 194. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Robin R. Johnson 1513 Cole St., Balto., Md. 21223 death. Page 6 may be must be 204. METHOD OF DISPOSITION

1 X Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 2/17 Crownsville Veterans Cem. 4 Donation 5 DOther (Specify) ... Crownsville, Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. Cu massey 5695 Main St., Elkridge, Md. ysician and completely filled in by the prior to burial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart salure. List only one cause on each line. IMMEDIATE CAUSE (Fine) the disease or condition COCAINE AND NARCOTIC INTOXICATION resulting in death) traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): has been signed by the attending physician Dept. of Health and Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST in ury, or PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? shows any 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) UNCERTAIN \(\square\) 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL DR ATTENDING PHYSICIAN: The After this certificate death with the State HOSPITAL OTHER: 1XXXES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 Dasidence 8 - Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Netural м -10-95 FOUND 1 YES 2 X NO ВY SUBJECT INGESTED DRUGS Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, streat, fectory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number City or Town, State) 1513 COLE STREET BALTIMORE, MD. 82 3 Sulcide DIRECTOR: A ETED. 8 Could not be Item 28 4 Homicide FOUND AT HOME 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(e) end manner as stated. COMPL (Check only one) TO THE HOSPITAL

TO THE FUNERAL I

Be filed within 72 h

IMPORTANT: If II 2 X MEDICAL EXAMINER: On the bests of exam in end/or investigation, in my opinion, death occured at the time, data end place, end due to the ceuse(a) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 8 29c. LICENSE NUMBER O.C.M.E 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Fowler

32. REGISTRAR'S SIGNATURE

31, DATE FILED (Month, Day, Year)

1905

FEB

3. TIME OF DEATH

1429

10d. INSIDE CITY

14. RACE — American Indien, Black, White, etc.

white

Approximate interval Between

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

DE DEATH? 1 PES 2 NO

29d. DATE SIGNED (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

▶ FEB. 11,1995

Onaet and Daath

1 NYES 2 NO

8. BIRTHPLACE (State or Foreign

Maryland

10g. CITIZEN OF WHAT COUNTRY?

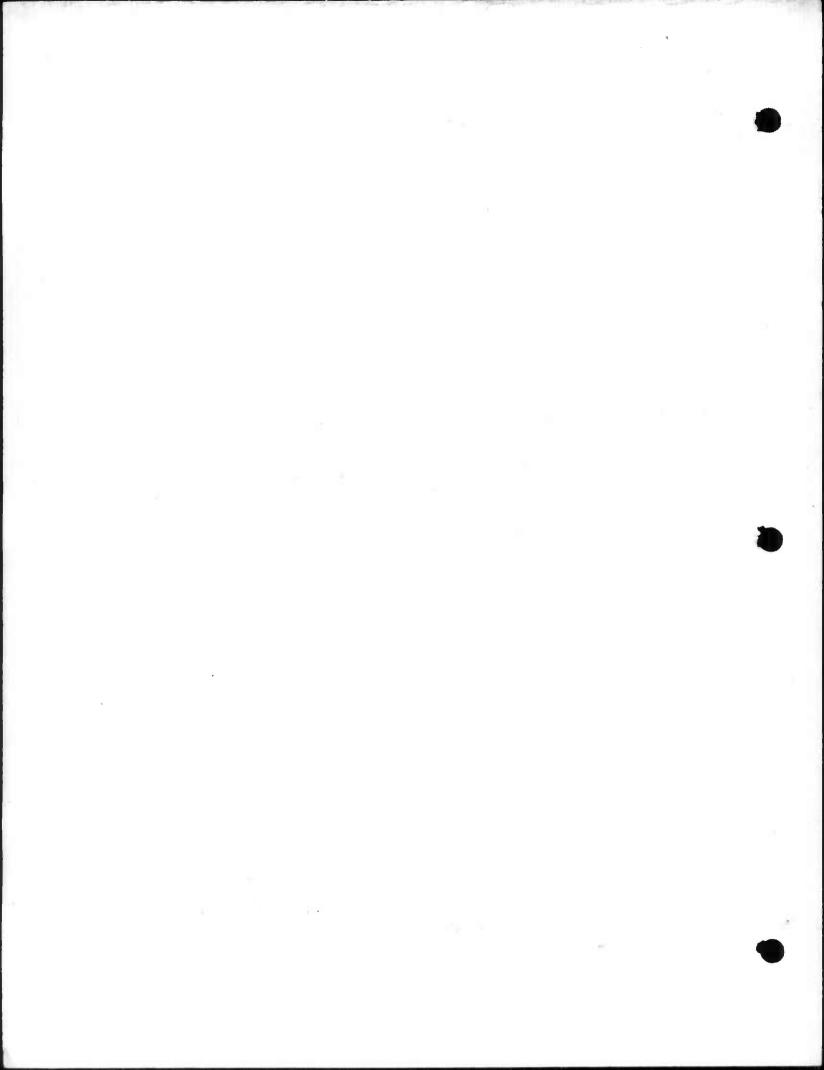
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9c. COUNTY OF DEATH

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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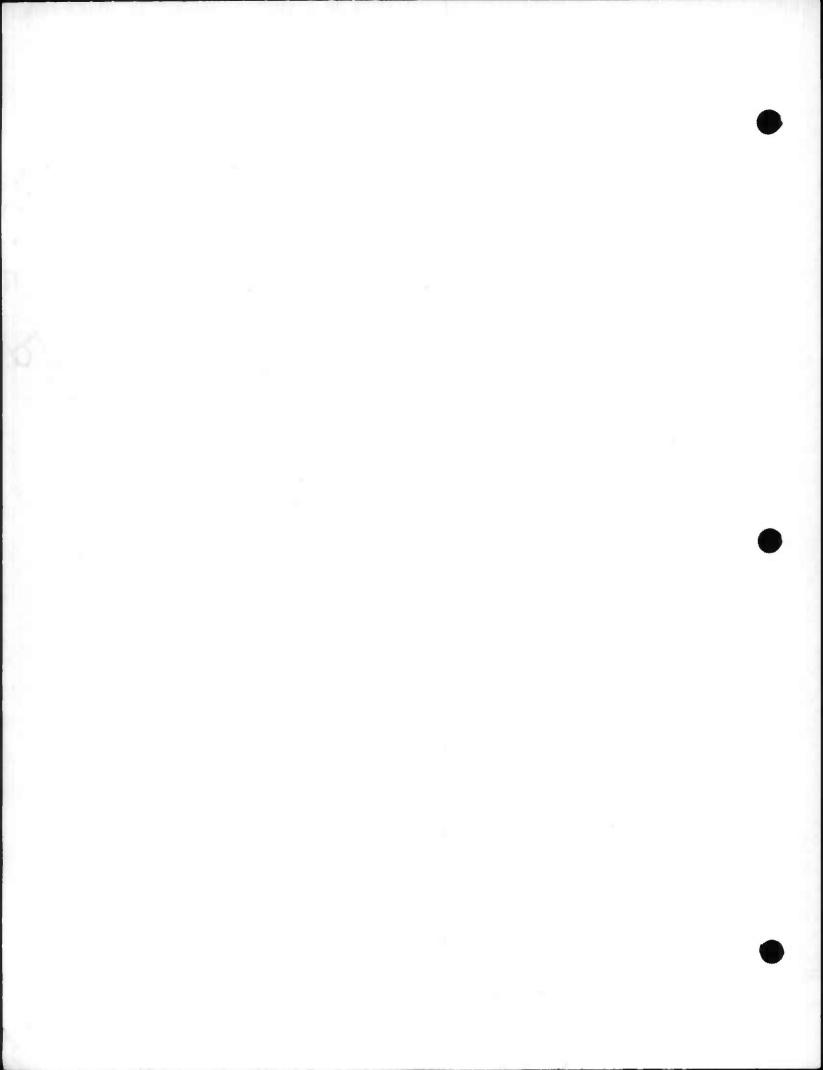
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FEB 1 6 1995

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending pl	¥	ithin 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	Miller Miller St. Start St. Start St. Start St. St. St. St. St. St. St. St. St. St
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. OECEOENT'S NAME (First, Middle 2. DATE OF DEATH MONTH 3. TIME OF DEATH 8. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. (Mor 9b. CITY, TOWN OR LOCATION OF DEATH FUNERAL DIRECTOR 11MORE RESIDENCE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 X YES 2 | NO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 KINO IF YES, GIVE WAR OR DATES 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Marrie BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION secify only highest grade complete 16s. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INOUSTRY College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First BE 19b. MAILING ADDRESS (Sh 2 8 20 METHOD OF DISPOSITION
1 S Burial 2 Cremation 3 4 Donation 5 Don 21. SIGNATURE OF ERAL SERVICE LICE GAPY diseases, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory arrest, **Approximata** shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death ASPIRATION PREVIOUPIA DUE TO (OR AS A CONSEQUENCE OF): LETASTATIC PROSTATE CANCER 1 disease or condition resulting in death) CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING 3 CAUSE (Disease or Injury that initiated eventa resulting in deeth) LAST PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 10 OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | UNCERTAIN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER: 1 | YES 2 | 400 etlant 2 - ER/Outpetlent 3 - DOA Home 5 ☐ Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation м 1 YES 2 NO BY 2 Acciden 26e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 3 Suicide 6 Could not be 4 Homicide 29a, CERTIFIER CERTIFYING PHYSICIAN: To the beat dgs, death occurred at the time, data and place, and due to the cause(s) and menner as stated 2 MEDICAL tion and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated TITLE OF CENTIFIE 29d. DATE SIGNED (Market Day Your) 296. SIGNATURE 29c. MCENSE NUMBER æ **₹** WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)



use as the burial-transit permit. Pages 1, 2, 3 should

	OF COMPLETED BY BUXELOIM. MEDICAL CONTINUES	1 0
examiner must be notified at once.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	=
e funeral director, page 5 should be detached for il.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	28
death. Page 6 may be retained by the hospital of	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with house after death. Page 6 may be retained by the hospital is	2

TATIANA MOURAVSKAIA, M.D.

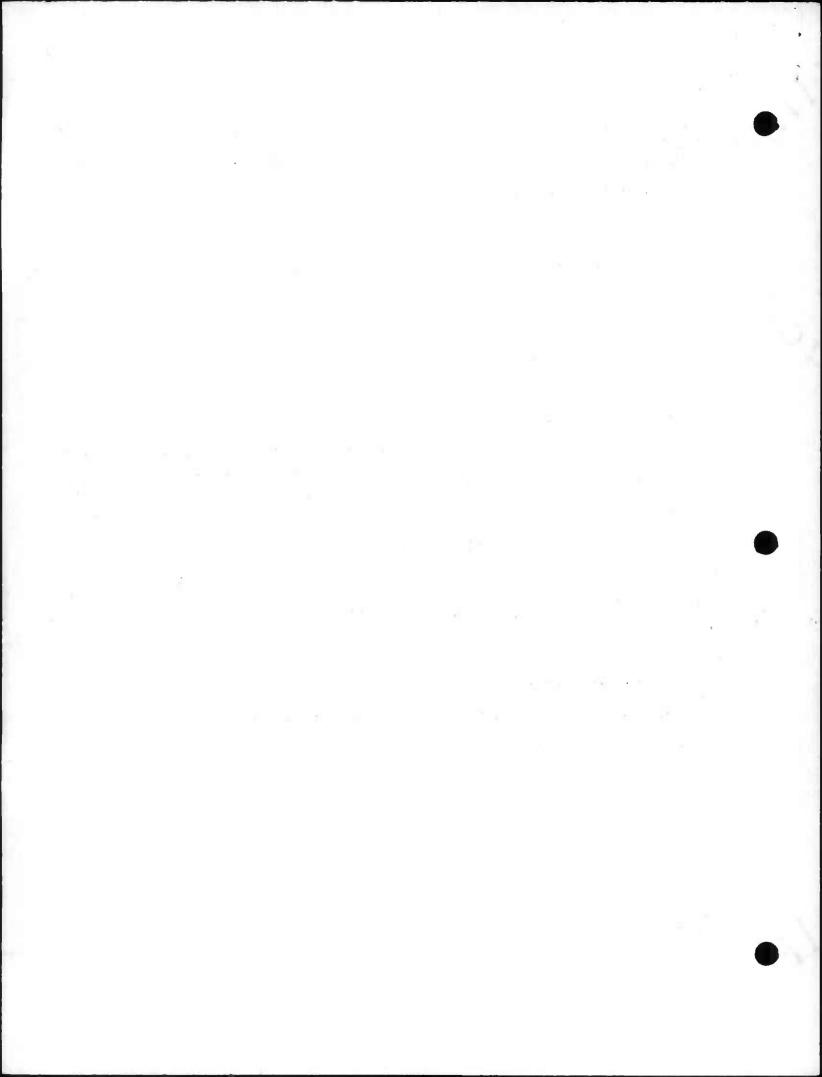
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	1 - STATE REGISTRAR	STATE OF MA	ARYLAND /	DEPAR	RTMENT OF H	EALTH A	AND N	MENTAL HYGIEN					
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	Dec. 2012/03/03/1995				IF UNDER 1 YEAR MONTHS DAYS	HOURS 24	MIN.	7. DATE OF BIRTH (Month, Day, Year)		Country		sign	
	070 34 1300	1 M 2 D F	51	YRS.				3/16/194	3	MARY	LAND		
	9a. FACILITY NAME (If not institution, give stre	et and number)			96. CITY, TOWN C	R LOCATION	OF DE	ATH	9c. COL	INTY OF DE	EATH		
DIRECTOR	MARYLAND GENERA	L HOSTIAL	(HOSP	ITAL	BALTI	MORE							
ត្ត	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			100 CIT	Y, TOWN OR LOCAT	1041							
<u> </u>						ION					10d. INSIDE CITY LIMITS?		
	MARYLAND 100. STREET AND NUMBER			В	ALTIMORE						1 XYES 2 A	10	
HA					101	. ZIP CODE			10g, CI1	IZEN OF W	HAT COUNTRY?		
N	2510 W. PATAPSCO					<u> 21225</u>			USA				
FUNERAL	11. MARITAL STATUS 1 🗓 Never Married 2 🗌 Married	12. WAS DECEDENT I FORCES? 1	EVER IN U.S. ARI	MED O	13. WAS DEC	ENDENT OF	HISPAN	IC ORIGIN? (Specify Year, Puerto Rican, atc.)	or No-	14. RACE Black,	- American Indian White, stc.	١,	
B	3 Widowed 4 Divorced	IF YES, GIVE WAF	OR DATES			2 X NO					AMERICA		
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COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ompleted)	(GA	ve kind of	USUAL OCCUPATION work done during mo se retired.)	on st of working		16b. KIND OF BU	SINESS/IN	DUSTRY			
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\$	17. FATHER'S NAME (First, Middle, Last)	4	IEA	ACHE	K					:			
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H P	IRVING W. KEELER	SK.				ELLE		ARNOLD					
2	198. INFORMANT'S NAME (Type/Print) IRVING KEELER SR.							Noute Number, City or Tow		0027			
	20g. METHOD OF DISPOSITION				OF DISPOSITION (Na		TOIG			City or Tow	rn. Stata		
	1 X Burial 2 Cremation 3 Remov	rel from State			EMETERY		/95				EW YORK		
	21. SIGNATURE OF FUNERAL SERVICE LICER	NSEE O	1		22. NAME AN	O ADDRESS	OF FAC	CILITY				_	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME, P.A.												
	Hurry 1	UM	ly		1300	EUTAW	PL	ACE, BALTI	MORE	,MD.	21217		
	23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or resolvatory except												
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	disease or condition A COLLEGED TANAHMODEET CLENCY CYNIDDOME												
	a. ACQUIRED IMMUNODEFICIENCE SYNDROME DUE TO (OR AS A CONSEQUENCE OF):												
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2	Sequentially list conditions, If any, leading to immediate b. CHRONIC RENAL FAILURE ON HEMODIALYSIS DUE TO (OR AS A CONSEQUENCE OF):												
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	resulting in death) LAST												
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₹	PART II. Other significent conditions		eetn out not re	esulting	in the underlying	g cause giv	ven in I	Part I. 24a. WAS AN PERFOR			WERE AUTOPSY FIN AVAILABLE PRIOR TO		
5	DIABETES MELL	LTUS						1 YES 2	XXNO		COMPLETION OF CA	USE	
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	DID TOBACCO USE C	ONTRIBUTE	TO CAUS	SE OF	DEATH Y	ES 🗆	NO	R					
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?					ACE OF DEA	ATH (Che	ck only one)					
5		HOSPITAL:	R/Outpatient 3	□ DOA	OTHER: 4 Nursing Hom	e 5 🗆 Reale	denca	8 Other (Specify)					
	27. MANNER OF DEATH	28a. DATE OF IN (Month, Day,	JURY Weet	28b. TIN		URY AT		28d. DESCRIBE HOW I	NJURY OC	CURED		-	
	T Natural 5 Pending 2 Accident Investigation	, som, pay,	,	174.		ES 2 1	NO						
اد	3 Suicide 8 Could not be	28e. PLACE OF I	NJURY — At hor	ne, farm,	street, fectory, offic			281. LOCATION (Street		r or Rural Ro	oute Number,		
<u>" </u>	4 Homicide datarmined	Sunding, att	a. (opecity)					City or Town, State)					
ן נ	29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the heat of my knowledge death account of the blank of the land.												
COMPLE	Cinch of the course (Check on the course) (C												
3				yatn	, my opninost, 0				u dull to t	rie cadse(8)	and manfier as sta	red.	
BE I	296. SIGNATURE AND TITLE OF CERTIFIER	/>	11.	10)	29c. LICENS	SE NUM	BER	29d, DAT	E SIGNED	(Month, Day, Year)		
3	- Quest	ej	, 10,	1.2	<i>/</i>				8	9224	1		
1	36. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (ITEM	1 27) (Type	, Print)								

c/o MARYLAND GENERAL HOSPITAL



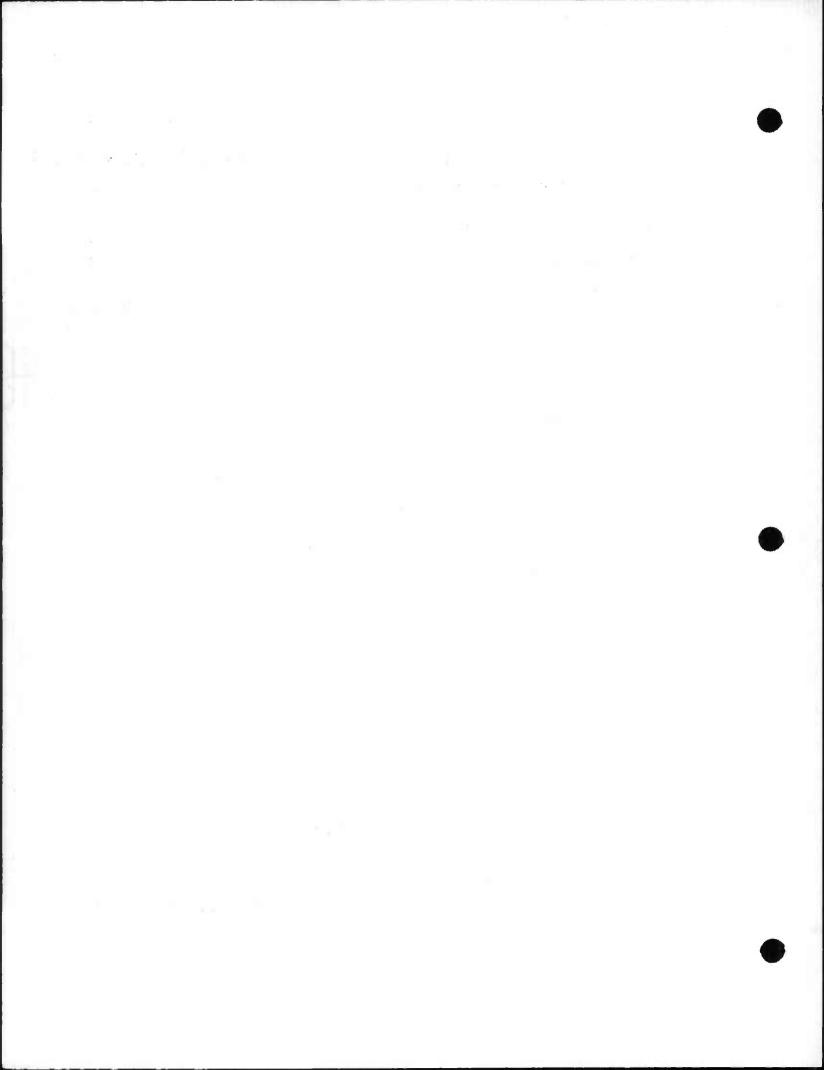
hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 HOME PHYSICIAN: The law requires that the death certificate be executed within 24 DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	FIGH. When this certificate has been signed by the attending physician and completely filled in by the human director, page 5 should be detached for	the draw with the State Dept. of Health and Mental Hygiene prior to burial, cremation, ur removal.	28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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TO THE HOSPIT TO THE FUNDA De fled within

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPAR	TMENT (F HEALTH	AND I	MENTAL HYGIEN REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last) WILLIAM M.	KANE					2. DATE OF DEATH FEB. I	Ď 9	3. TIME OF DEATH 1350 P M			
		5. SEX 6. AGE (In yrs. 1	last birthday) YRS.		AYS HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Year)	918 B	BIRTHPLACE (State or Foreign Country) ROOKLYN N.V.			
TOR	ODEN HAL AVENUE		ROAD		THERSI			PC. COUNTY	GOMERY			
DIRECTOR	10e. STATE 10b. COUNTY	T.C. Marie V.	10c, CITY	TOWN OR L	OCATION				10d. INSIDE CITY LIMITS?			
AL D	100. STREET AND NUMBER	GOMERY	1 GA	17/11	101. ZIP COD	RE		10g, CITIZEN	1 YES 2 NO			
FUNER	18700 WALKER	- 101Cap	D.		20	379			· 5.A.			
D BY FU	1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT, EVER IN U.S. / FORCES? 1 V YES 2 FIF YES, GIVE WAR OR DATES	ARMED NO - 94	If ye	B DECENDENT (HB, specify Cuba YES 2 NO	OF HISPAN In, Mexican Specify	IC ORIGIN? (Specify Yea n, Puerto Rican, etc.)	or No.— 14	RACE — American Indian, Black, White, etc. Specify:			
ETE	15. DECEDENT'S EDUCA' (Specify only highest grade co	empleted)	ile. Do NOT use	ork done durir retired.)	IPATION ng most of workin	ng	16b. KIND OF BUS					
COMPL	17. FATHER'S NAME (First, Middle, Last)		CLE	PK	18 MOT	MED'É MAI	TWIEL-	-	PAL ORG.			
BE C	ROBELT	KANE			16. MO11	-	ABELLA	MART	YN			
10	190. INFORMANT'S NAME (Type/Print) HELEN KANE		18700				ICE P.D. SI	Store, Zip Co	esquee MD			
	METHOD OF DISPOSITION Burlel 2 Cremetion 3 Remove Donation 5 Other (Specify)		E AND DATE OF	er place)		2-1		ATION — City	or Town, State			
	21. SIGNATURE OF FUNERAL SERVICE LICEN	Sky l. l	J 6 17 K		AE AND ADDRE	SS OF FAC	2010 Dig 17	b, Mi	21224			
	23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a											
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death											
_	PART ii. Other significant conditions	contributing to death but not	resulting in	the under	lying ceuse of	jiven in I	Part i. 24a. WAS AN / PERFORI		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO			
PHYSICIAN: MEDICA						_	1 FES 2		COMPLETION OF CAUSE OF DEATH?			
N. N.	DID TOBACCO USE CONTRIL	BUTE TO CAUSE OF DE	ATH YES	□ NC	UNC	ERTAIN			1 Pres 2 No			
SICIA		26. PL/ HOSPITAL: □ Inpetient 2 □ ER/Outpetient		OTHER:			VV D	O V DIAI V	V			
PHYS	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 280	Home 5 Re	eldenca (26d. DESCRIBE HOW IN					
ВУ	1 Netural 5 Pending	2-10-95	134	M 1	YES 2		Drner -	auton	obile collision.			
TED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At I building, etc. (Specify)		reet, fectory,	office		281. LOCATION (Street and Number or Rural Route Number. City or Town, State) Odon had our of Confure Ad					
COMPLETED		N: To the best of my knowledge, of On the beele of examination end/or					to the cause(e) end mans		suas(e) end manner as stated.			
BE	29b. SIGNATURE AND JUFLE OF CENTIFIER	Plal				C . M		29d. DATE SI	GNED (Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Owid R Fowler 111 Penn Street, Baltimore, Maryland 21201											
	31 DATE FILED (Month, Day, Yeer)	32. REGISTRAR'S SIGNATURE			3							
	FEB 1 6 1995 Julia	. Dawoler Kardall										

DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

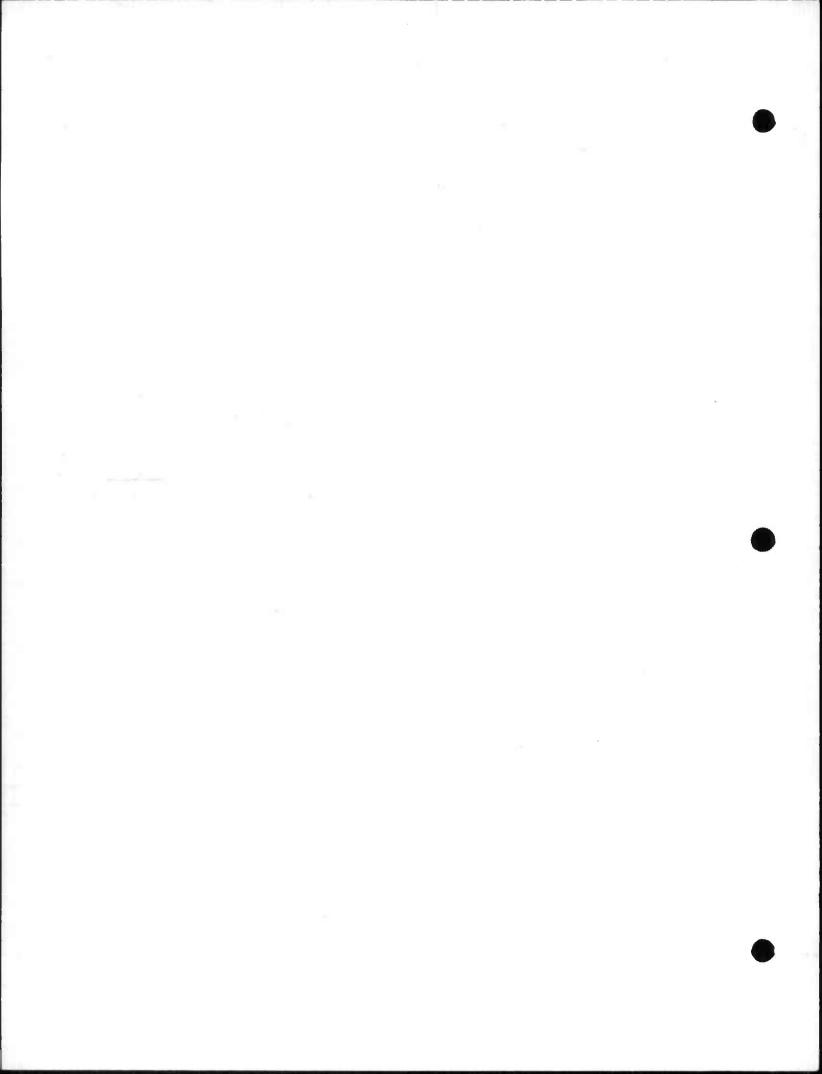
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATN 2. DATE OF DEATN LOTTIE KASZUBINSKI DAY YEAR Feb. 14, 1995 11:39 AM 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) | IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year 8. BIRTNPLACE (State or Foreign IF UNDER 24 HRS. 214-14-0557 103 MONTHS DAYS HOURS 1 M 2 X F YRS Mary land Nov. 26, 1891 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN North Arundel Hospital Association Glen Burnie Anne Arundel DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION
Millersville 10d. INSIDE CITY LIMITS? Mary land Anne Arundel 1 YES 2 X NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8286 Pond Court funeral director, page 5 should be detached for use as the burial-transit 21108 USA Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES ВУ Specify: 3XXWidowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 18a. DECEDENT'S USUAL OCCUPATION 18h KIND OF BUSINESS/INDUSTRY ntary/Secondary (0-12) College (1-4 or 5 +) Housewife and Mother Homemaker Unknown 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surname) Pawl owsk i John te Mary BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8286 Pond Court, Millersville, Md. 21108 Mrs. Mary Streets pe 20e. METNOD OF DISPOSITION
1 № Burlel 2 □ Cremation 3 □ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must Holly Cross Cemetery 2/17/95 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner McCully Funeral Home of Broolyn BROOKLYN Kevin E. Ecker 237 E. Patapsco Ave., Balto., Md. 21225 completely filled in by the medical 23. PART I. Enfer the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List pnly one ceuse on each line. intervel Between 0 IMMEDIATE CAUSE (Finel Onset and Death the cremation, disease or condition event, resulting in death) the attending physician and con Mental Hygiene prior to burial, traumatic CERTIFICATION ear Sequentially list conditions, prior to If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury or other DUE TO (OR AS A CONSE WINCE OF thet initiated events resulting in deeth) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS and and AVAILABLE PRIOR TO COMPLETION OF CAUSE any signed the 1 TYES 2 LINO OF DEATH? 1 TES 2 NO has been s Dept. of H n 23 shov DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: HOSPITAL OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) this certificate h HOSPITAL OTHER: 1 YES 2 - NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Reeldence 8 Other (Specify) or or 27. MANNER OF DEATH 28b. TIME OF INJURY 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED marked, 1 Natural 5 Pending L DIRECTOR: After the bours after death w BY 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, ferm, street, fectory, offica building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. 3 Suicide 8 Could not be 4 Homicide datermined 29e. CERTIFIER

(Charle and)

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end manner ee stated. COMPL TO THE HOSPITAL
TO THE FUNERAL I
Be filed within 72 h
IMPORTANT: If it 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(a) and manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER H たり 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4710 Pennine er un Md-2122(32 AEGISTRAR'S SIGNATURE 1995

wind Samidam - Ro



020	physician
BALTIMORE, MARYLAND 21215-0020	affending
021	spital or
LAN	the ho
MARY	death. Page 6 may be retained by the hospital or attendin
E,	y be r
OR	6 ma
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3AL	r death
ш	nin 24 hours after de
	4 hou
90	within 2
687	executed
ŏ	be e
, P.O. BOX 68760	certificate
s, P.O	death

ND 21215-0020

this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit with the State Dept, of Health and Mental Hygiene prior to burlat, cemation, or removal.

**Action of them 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

permit. Pages 1, 2, 3 should

BY FUNERAL DIRECTOR

BE COMPLETED

9

CERTIFICATION

PHYSICIAN: MEDICAL

В

COMPLETED

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2

film 28 is marked, or

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DIRECTOR

Bar.

P P # 1

If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST

27. MANNER OF DEATH

5 Pending

8 Could not be determined

Investigation

1 Natural

2 Accident 3 Suicide

4 Homicide

DIVISION OF VITAL RECORDS OR ATTENDING PHYSICIAN: The law requires that the

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.													
1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATH	
	Do	min ic	K	a sz u	binsk	i			Feb. 13,	1995	YEAR		h
4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In yrs. last		IF UNDER 1 YE	-	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTI	IPLACE (State or Foreign	_
215-10-416	3	1 18 M 2 - F	79		YRS.	MONTHS DA	SA!	HOURS MIN.	April 7, 19	15	Mar	vland	
9a. FACILITY NAME (If not in	stitution, give s	treet and number)				9b. CITY, TO	WN O	R LOCATION OF DE			INTY OF D	DEATH	_
8286 Pond	Court					Mil	1e	rsville		Ann	e Ar	unde 1	
RESIDENCE OF DEC	CEDENT												
10a. STATE	10b. COUNTY					TOWN OR L						10d. INSIDE CITY LIMITS?	
Maryland	Wico	m <u>ico</u>			0c	ean C	it	У				1 X YES 2 NO	
10e. STREET AND NUMBER							101.	ZIP CODE		10g. CIT	IZEN OF V	WHAT COUNTRY?	ī
522 Nautic	al Lan	е						21842		Uni	ited	States	
11. MARITAL STATUS		12. WAS DECEDED							IIC ORIGIN? (Specify Yes	or No-	14. BACI	E — American Indian,	_
1 Never Married 2		IF YES, GIVE Y	MAR OR DA		O	If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:					7000	Black, White, etc. Specify:	
3 Widowed 4 Divo	orced	1941- 1	945									White	
15. DECEDENT'S EDUCATION 16a. DECEDENT (Specify only highest grade completed) (Give kind of the completed)					ISUAL OCCU			16b. KIND OF BUS	SINESS/IN	DUSTRY		_	
Elementary/Secondary (I		College (1-4 or 5	+)	lite. Do NOT use retired.)									
8		0		Warehouseman					Western Electric Company				
17. FATHER'S NAME (First, M	liddle, Last)						\neg	18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)			
Domin i	ck		Ka sz	ubin	ıbinski Lottie Pawlow					vski			
19a, INFORMANT'S NAME (Type/Print)					ADDRESS (St	reef ar	nd Number or Rural I	Route Number, City or Town	n, State, Zi	ip Code)		_
Mary Stre	ets			82	86 Pc	ond Co	ur	t Miller	sville, Mar	y lar	d 2	21 108	
20a. METHOD OF DISPOSIT			20b	PLACEA	NDDATEO	FDISPOSITIO	N (Nai	me of	DATE 20c. LO	CATION -	City or To	own, State	
4 Donation 5 Other		Ovisi from State	Cen M	netery, grematory or other place. eadowridge Mem. Park 2/17/95 Elkridge. Maryland							lary land		
21. SIGNATURE OF FUNERA	L SERVICE LIC	ENGRE	1)	90.00		-		D ADDRESS OF FA	CILITY				
1/20 xx X. Colinuk						McC	u1	ly Funer				tapsco Ave Md. 21225	<u>,</u>
	eart failure.	complications the List only one car	et ceused use on e	the de ach iine	eth. Do no	ot enter the	mod	de of dying, suc	h aa cardlec or respi	ratory a	reat,	Approximate Interval Betwee Onset and Dec	
IMMEDIATE CAUSE (Final) disease or condition				0401011							1000	-	
resulting in death)		B. OUE TO	OR AS	CONSEC	MENCE OF	c me	0	V /10	many			1 work	>
		-	1	7	0.0		()	- H.	A			010	
Sequentially list condit	lone T		20	COU	2	Las	14	7 mount	2-12-5			10 leas	

PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i.

24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 70

24b. WERE AUTOPSY FINDINGS **AMILABLE PRIOR TO** COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 2

25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 PER/Outpetient 3 | DOA 1 YES 2 NO 4 Nursing Home 5 Rasidence 6 Other (Specify)

28b. TIME OF 28a. DATE OF INJURY (Month, Day, Year)

28a. PLACE OF INJURY — At home, farm, street, tabuilding, etc. (Specify)

28c. INJURY AT WORK? 1 YES 2 NO

28d. DESCRIBE HOW INJURY OCCURED

29a. CERTIFIER (Check only

29b. SIGNATURE AND THELE OF CENTS DATE SIGNED (Month, Day, Year)

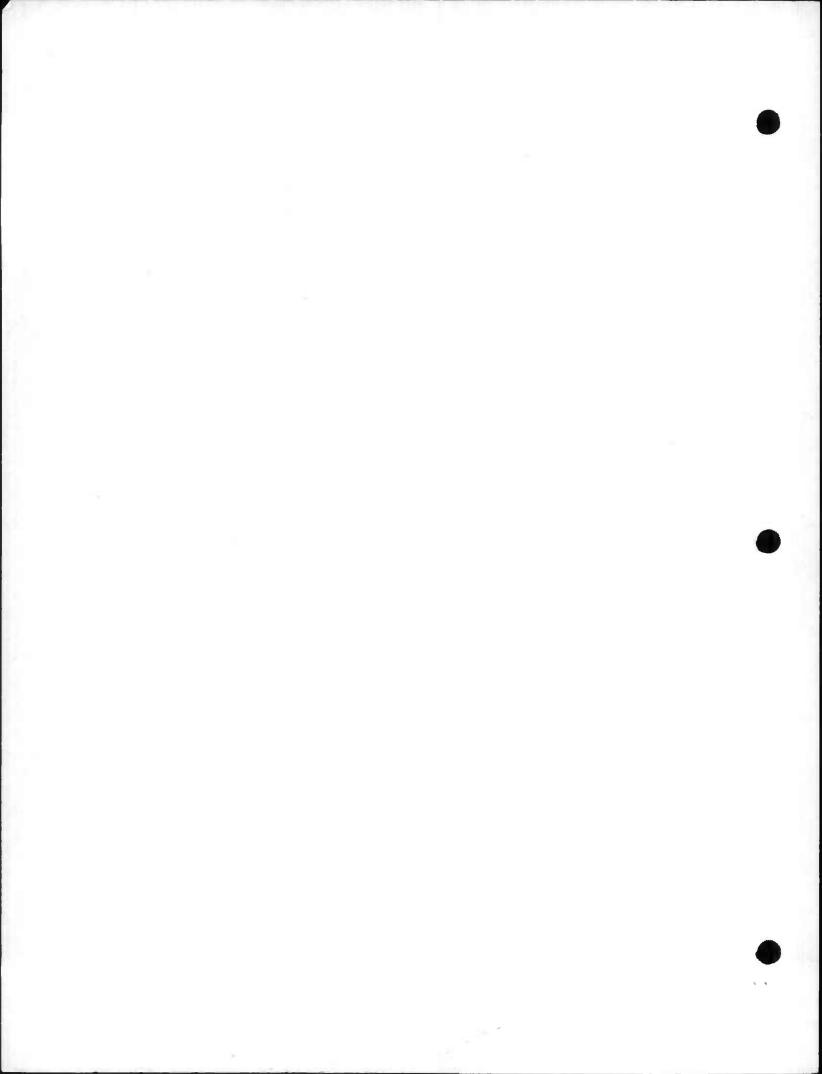
30. NAME AND A AUSE OF DEATH (ITEM 27) (Type,

32, AGGISTICARIE TIGNATORIA

31. DATE FILED (Mo

DHMH-18 Rev 1/89





DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page be filled within 72 hours after death with the State Denr. of Health and Mental Hollege prior to burial, cremation, or removal	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL OR ATTENC	O THE FUNERAL DIRECTOR:	MPORTANT: If item 28 is

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

	REGISTRAN				OLIT	11111	AIE UF	DEAL	11	REG. NO					
	1. DECEDENT'S NAME (First	у К	insey	2. DATE OF DEATH DO FEBRAURY											
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In	yrs. lest birt	thday)	F UNDER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH		S. BIRTHI	PLACE (State or Foreign		
1 1	212-40-5543	3	1X M 2 - F	59	9 1	YRS.	ONTHE DAYS	HOURS	MIN.	(Month, Day, Year) Oct. 7, 19	35	Ra 1	to. Md,		
	9a. FACILITY NAME (If not in	astitution, give	street and number)			-	b. CITY, TOWN	OR LOCATIO	NI OF DE			NTY OF DE			
Œ	Sinai Hospital						o. om, town		timo		9c. COD	City			
12	RESIDENCE OF DEC	-				В	altim	ore			City				
DIRECTOR	10a. STATE	10b. COUNT	ry		10	Dc. CITY.	TOWN OR LOCA	TION					10d. INSIDE CITY		
E	Md.	Ci	tv			,	_	imore			LIMITS?				
	10e. STREET AND NUMBER							-		1 YES 2 NO					
FUNERAL			_			101. ZIP CODE					10g. CITIZEN OF WHAT COUNTRY				
	1803 Thornbury Road 21209											U	SA		
5	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1						C ORIGIN? (Specify Ye	or No-	- American Indian, White, atc.				
BY	1 X Never Married 2 3 Widowed 4 Divo		IF YES, GIVE W	AR OR DAT	ES			ZID NO				Specify			
	3 Mounta 4 Dive	исец									l		White		
COMPLETED	15, DEC (Specify onl	EDENT'S EDU	UCATION le completed)	1	CONTRACT IN	de ed come	BUAL OCCUPATI k done during m			16b. KIND OF BU	SINESS/INC	DUSTRY			
9	High School		College (1-4 or 5 +)	life. Do	NOT use i	etired.) Emp	love	d						
틸	High School	'1			E-m	paye	at B	.A.R.	C. 🖈	630 .					
0	17. FATHER'S NAME (First, M	liddle, Last)						18. MOTN	IER'S NAM	E (First, Middle, Meiden	Sumame)				
	Leonard	I D. K	insey Sr.					4		abeth Mor					
BE	19a. INFORMANT'S NAME (Inde, br.		19b. M/	AILING A	DDRESS (Street			oute Number, City or Tow		Codel			
유	Mrs. Shirle		Smith							Reisters			21136		
	20g. METHOD OF DISPOSIT	-		200 0			DISPOSITION (N								
	1 N Burial 2 Crematic	n 3 🗆 Ren	noval from State	cemen	ery, cremato	B d. ohio	e Ceme	t o xxx	2				y or Town, State		
	21. SION ATURE OF FUNERA		ICENSEE	_ DI	.u.iu	KIUg	1	ND ADDRES			ikesville, Md.				
		æ	0/	*						118			rstown Rd.		
	Lano		Xolin	· ·			Eline	Fune	ral	Home Rei	sters	town	, Md. 21136		
	23. PART I. Enter the d	iseases, or	complications that	caused t	the daeth.	. Do not	anter the mo	de of dyln	ng, such	sa cerdiac or resp	ratory arr	rest,	Approximate		
	ahock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF):														
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): SEPSIS														
	PART ii. Other algnifica	nt condition	ne contributing to	deeth but	not resul	itina in	the underlyin	a ceuse a	lven in P	Part I. 24a. WAS AN	AUTOPSV	245	WERE AUTOPSY FINDINGS		
EDICAL							,			PERFO			AMAILABLE PRIOR TO COMPLETION OF CAUSE		
									_	1 YES 2	□ NO		OF DEATH?		
2													1 TYES 2 NO		
SICIAN:	DID TOBACCO U		RIBUTE TO CA						ERTAIN						
∂	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	26	3. PLACE OF		(Check only one)								
S	1 TYES 2 NO		1 Ninpetient 2	ER/Outpati	lent 3 🗆 D		THER: Nursing Non	10 5 A Res	sidence 8	Other (Specify)					
РНҮ	27. MANNER OF DEATN		28a. DATE OF (Month, Di	INJURY tv. Year)	28	b. TIME C		URY AT		28d. DESCRIBE HOW I	NJURY OC	CURED			
ВУ		Pending Investigation		,				YES 2	NO						
	2 Deviates —	Could not be	28e. PLACE O	F INJURY -	At home, i	form, stre	et, factory, offic			28f. LOCATION (Street	and Number	or Rural Ro	ute Number,		
ETED		determined	ounding,	erc. (Specify	-					City or Town, State)					
۳	29a. CERTIFIER	TEVINO PHYS	CIAN: To the heat of	mu be suite d	da da ab										
COMPL	(Check only Time CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(s) and manner as stated.														
29c. LICENSE NUMBER 29d. DATI										e cause(s)	and menner as stated.				
										29d. DAT	E SIGNEO (Month, Day, Year)			
0	ATOXIA! PHEKAURI 13 199									13,1995					
	30. NAME AND ADDRESS OF								0.55						
	+DUDEL C	DUKK	MS, 511V	AI H	JOPLI	AL	W.BL	IVEL	DERL	EAVE, B	AITI	MOR	E, MO		
	31. DATE FILED (Month, Day, FEB	7 6 10	95 32. REGISTRA	R'S SIGNAT	URE		a.								
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DIVISION	

	_	1	FOR STATE REGISTRAR	STATE OF MARYL				EALTH AND DEATH	MENTA	L HYGIEN			
		ì	1. DECEDENT'S NAME (First, Middle, Last)	elder	er 2. DATE OF DEATH DAY YEAR February 12, 1995					YEAR	TIME OF DEATH		
should			4. SOCIAL SECURITY NUMBER 219-05-5736 90. FACILITY NAME (If not institution, give st	1 □ M 2X F 73	(in yrs. lest birtho	MONTHS		IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mont	OF BIRTH th, Day, Year) 0/28/19	921	Maryla Maryla	and Lad
23	2		99. FACILITY NAME (If not institution, give street and number) 90. CITY, TOWN OR LOCATION OF DEATH 905 Dalton Avenue Baltimore Besidence of Decedent										
ift. Pages 1.	OFFICE	5	10a. STATE 10b. COUNTY Marvland			CITY, TOWN	OR LOCAT		ındal	k			. INSIDE CITY LIMITS? YES 2 1 NO
n. ansit permit.	I VOJ	IELAL	905 Dalton Avenu	e			101	ZIP CODE	OSHILL TO			ited	COUNTRY? States
ND 21215-0020 hospital or attending physician, ached for use as the burial-transit	>0 NI II	5	Never Merried 2 Merried FORCES? 1 YES 2 NO If yes, specify Cuben, Maxican, Puerto Rican, etc.) Black									Black, Wh	American Indian, life, atc.
27275 oital or attend of for use as	ETE	; 	15. DECEDENT'S EDU(Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	life. Do N	d of work done OT use retired.	during mo.	ON st of working	168	. KIND OF BU			
₹ ₹	at once.	- 111	8 Years 17. FATNER'S NAME (First, Middle, Last)		ПО	usewi:	ce	16. MOTNER'S NA		Middle, Maiden		e	
A H tained I	TO BE) [William F. Schaf			Anna M. Eberwein ADDRESS (Street and Number or Rural Floute Number, City or Town, State, Zip Code)							
63 44	2		Chris Lingenfeld 20a. METHOD OF DISPOSITION	200	. PLACE AND D			th Pt. I	Road		alk, M		222
Page 6 may be if director, page	ır must	Į	150 Buriel 2 Cremation 3 Remote A Donation 5 Other (Specify)	oval from State	netery cremetory	or other plece	etery	02/15/	/1995		altimo		
death.	al examiner		22. NAME AND ADDRESS OF FACILITY Duda—Ruck Funeral Home of Dunc 7922 Wise Ave. Dundalk, MD								212	•	
within thours	event, the medical		23. PART I. Enter the diseases, or shock, or beart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause on a	neta	stat		color				st,	Approximate Interval Between Onset and Death
be execution and	traumatic		Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury c.										
ath certil	or of		that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):										
and the company of th	any inju		PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO									AMAII	E AUTOPSY FINDINGS LABLE PRIOR TO IPLETION OF CAUSE DEATH?
v requ	23 shows		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										YES 2 NO
the H	Te Te		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	26. PLACE OF	OTHE	R:		a				
PHYSICIA this certif	ked, o		27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28a, DATE OF INJURY 28b TIME OF			URY AT RK?	6 ☐ Other (Specify) 28d. DE\$CRIBE HOW INJURY OCCURED				
TEN S	ے ا≃ 5	4	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, term, street building, etc. (Specify)						28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
	ANT: If item 28 COMPLETE		29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
TO THE HOSPITAL TO THE FUNERAL			296. SIGNATURE AND TITLE OF CERTIFIER	d attac	ww			D-Z		7	29d. DATE 5	IGNED (Mon	oth, Day, Year)
2	١٦		30. NAME AND ADDRESS OF PERSON WHO	22 REQISTRAT'S SIGN		Type, Print)							
		III.	LLUI'K' MYOF	A Maria a sign	CJ-115e A								

DALLIMONE, MANICALE	s after death. Page 6 may be retained by the hosp	by the funeral director, page 5 should be detache emoval.	dical examiner must be notitled at once.	
	TO THE HOSPITAL OR APPLICATE PHYSICAL THE law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DESCRIPTION After this primitate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after the mental filed within 72 hours after the filled within 72 hours af	IMPORTANT: It Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAN				CERTIF	ICALL	E OF	DEAL	111		REG. NO.			
	1. DECEDENT'S NAME (First,		VELYN	LEV	ENTHAL	Ĺ				2. DATE OF MONTH Febru	DEATH DA	ğ, 19	YEAR 995	3. TIME OF DEATH 8:50 p.m. M
- 1	4. SOCIAL SECURITY NUMBER 5. SEX			6. AGE (In yrs. last birthday)		IF UNDER	1 YEAR	IF UNDER	24 HRS	7. DATE OF		, 1.		IPLACE (State or Foreign
	186-16-7514	106 16 751/. Month, Days Hours Min. (Month, Days						ly, Year)	191	Count	rbondale, PA			
	9a. FACILITY NAME (If not in:		eet and number)			9b. CITY	, TOWN	OR LOCATIO	ON OF DE			9c. COU	NTY OF E	DEATH
S S	3 Seiler Co					Re	iste	rsto	wn			В	alti	more Co.
ទ	RESIDENCE OF DEC	10b, COUNTY			100 CIT	CITY, TOWN OR LOCATION 10d III					lan vilanona a sassi			
DIRECTOR	MD		more Co	•		eist								10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	3 Seiler Co	urt					101	. ZIP CODI	2113	36		-	SA.	WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2	X3NO		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 TANO Specify: 1 YES 2 TANO Specify:					E — American Indian, k, White, etc.		
		EDENT'S EDUC		184	. DECEDENT'S	USUAL O	CCUPATIO	ON		16b. KII	ID OF BUS	INESS/INE	DUSTRY	
COMPLETED	Elamentary/Secondary (0	highest grade o	College (1-4 or 5	+)	(Give kind of life. Do NOT u. Housew		during mo	st of workin	ng					
Š	17. FATHER'S NAME (First, Mi			-						AE (First, Midd	le, Maiden	Surname)		
BE	Oscar Hu	inter						Gt	wendo	olyn	Will	iams		
5	Susan L.									oute Number, o				
	20a, METHOD OF DISPOSITION 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	n 3 🗆 Ranio	val from Stata		ACE AND DATE y, crematory or o Cholso:				2/:	DATE 13/95		holse		
	21. SIGNATURE OF FUNERAL	SERVICE LICE	INSEE G	0				Fund		77				rstown Rd.
	M	1	00											, MD 21136
	23. PART I. Enter the di shock, pr he IMMEDIATE CAUSE (Fin disease or condition recuiting in death)	ert Tellure. L	let only one cet	cha	lina.								reet,	Approximate Interval Between Onset and Death
N	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Bronchal veolar Carcinoma of Lung Due to (or as a consequence of): Chemic Obstructive Pulmonay Disease Sequentially list conditions.													
RTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury													
ERTIFI	that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):													
ျု	PART II. Other eignificer	nt conditions	contributing to	death but n	not reaulting	in the ur	deriving	CRUMP C	alven in I	Part I 24	WASAN	Allmoev	245	. WERE AUTOPSY FINDINGS
₹	PART II. Other eignificent conditions contributing to death but not re										PERFORMED?		240	AVAILABLE PRIOR TO COMPLETION OF CAUSE
		,	0-10-		1					_ 1	YES 2	NO		OF DEATH?
<u>.</u>	DID TOBACCO US	SE CONTR	IBLITE TO CA	LISE OF D)FΔTH YE	S P	NO F	LINC	ERTAIN					1 TYES 2 NO
SICIAN:	25. WAS CASE REFERRED TO		IDOTE TO C.		PLACE OF DEA			JOITE	LKIAII					
S	EXAMINER?		HOSPITAL:	ER/Outpetler	nt 3 🗆 DOA	OTHER 4 Nur		5 × 80	eldence I	B C Other (Sp	uncifi.d			
⋛∦	27. MANNER OF DEATH		28a. DATE OF	INJURY	28b. TIM	E OF	28c. INJ	URY AT	alderica (28d. DESCRI		JURY OC	CURED	
<u>_</u>		Pending nvestigation	(Month, D	ay, Year)	INJ	URY M		RK? /ES 2 [NO					
TED B	3 Sulcide 8 0	Could not be	28e. PLACE O	F INJURY — A atc. (Specify)	At home, ferm,	street, fect	tory, office			281. LOCATIO	N (Street a	nd Number	or Rural F	Poute Number,
	29a. CERTIFIER					_						_		
29a. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as a						a) and mannar as stated.								
ᇤ	296. SIGNATURE AND TITLE	OF CERTIFIER	101	M)			29c. LICE	SZ1	BER FY		29d. DAT	SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF Dr. Jonath			SE OF DEATH				ر سا	<u> </u>				×11°	13
-	31. DATE FILED (Month, Day,)		P, REOISTRA			ISTHE	:55 (ente	r Dr	ive,	keist	erst	own,	MD 21136
	LFR 1 6 133	5 July	A WILLIAM	Martale										

BALTIMORE, MARYLAND 21215-0020

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OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	The functal CHECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It is a stream of the function of the first permit of Health and Mental Hygiene prior to burial, cremation, or removal.	the marked or item 23 chara any injury or other fraunatic event the marked araminer must be notified at ourse
MINGSO MINGSO	PAR 72	WITH
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TO BE COMPLETED

							95	0	4897
	FOR STATE REGISTRAR	STATE OF MA			IT OF HEALTH AND	MENTAL HYGIEI			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN		3.	TIME OF DEATN
	Barbara Nel	son Mille	er			FER-RUARY	15 199	EAR	5:05 AM
1 3	4. SOCIAL SECURITY NUMBER		. AGE (In yrs. lest birthda	/) IF UND	ER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8.	BIRTHPL/	ACE (State or Foreign
1 3	210 10 1005	1 M 2 XF	93 YRS.	MONTHS	DAYS HOURS MIN.	July 18	190	Ma	ryland
1_	9a. FACILITY NAME (If not institution, give s	,		9b. CIT	TY, TOWN OR LOCATION OF		9c. COUNTY	OF DEAT	Н
P	Union Memor	ıal Hosp	ıtal		Baltimore	City			
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	Y	10c. C	ITY, TOWN	OR LOCATION			10.	d. INSIDE CITY
H	Maryland				nore , City				LIMITS?
	10e. STREET AND NUMBER		1 00	11 6111	101. ZIP CODE		10g. CITIZE		T COUNTRY?
FUNERAL	3811 Canterbury	Road			21218		1 '	S.A.	
5	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. ARMED	13	. WAS DECENDENT OF NISP	ANIC ORIGIN? (Specify Y			American Indian, hite, etc.
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE WAR			Il yes, specify Cuben, Mexic 1 ☐ YES 2 ☑ NO Spec			Black, W Specify:	hite, etc.
	*	l							ite
TED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	18e. DECEDENT	of work done	e during most of working	16b. KIND OF BI	JSINESS/INDUS	TRY	
1 2	Elementary/Secondary (0-12)	100000000000000000000000000000000000000	life. Do NOT use retired.)						
COMPLET	17. FATNER'S NAME (First, Middle, Last)	Home Maker			Own Home AME (First, Middle, Meiden Surname)				
						n Sumeme)			
BE	John W. Nelson 190. INFORMANT'S NAME (Type/Print)		19b. MAILI	NG ADDRES	SS (Street and Number or Rura	Bulgen Boute Number City or To	en State Zin Co	orio)	
2	19e. INFORMANT'S NAME (Type/Print) Mrs. Elizabeth Rogers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stafe, Zip Code) 5 Shawnee Ct. Apt. 201 21234								
	20e. METHOD OF DISPOSITION		20b PLACE AND DAT	FOFOISPO	OSITION (Name of	DATE 20c I	OCATION — City	y or Town.	State
	1 X Burlel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval Irom State	Parkwood	gremetory or other place) kwood Cemetery 2/18/95 Balto. Md.					1393.2
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE //		22	2. NAME AND ADDRESS OF F	ACILITY			
	Mrs. del Co Select	1. 1/			Leonard J. F				
	23. PART i. Enter the diseeses or	complications that c	eused the deeth. Do	not ente	5305 Harford	JRU. Balto.	MQ. Z	1214	Approximate
	shock, or heart failure.	List only one ceuse	on each line.				matory arrow	**	interval Between
	iMMEDIATE CAUSE (Finel disease or condition	PERF	BRAL JA	1-00					Onset and Death
	resulting in death)		R AS A CONSEDUENCE		<u></u>				TEAR
z		b HTM	/						10 YEARS
TIFICATION	Sequentially ilst conditions, if any, leading to immediate		R AS A CONSEDUENCE	OF):					
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	cause. Enter UNDERLYING CAUSE (Disease or Injury	c							
	that initiated events resulting in death) LAST	DUE TO (OF	R AS A CONSEDUENCE	OF):					
CER	readiting in death) Exist	d							
	PART il. Other significent condition	s contributing to de	ath but not reaulting	in the u	underlying ceuse given is	n Part i. 24a. WAS A		24b. WE	RE AUTOPSY FINDINGS
MEDICAL	ATMAL FIBRILATION, HYPOTHYRONISM CORDNARY ARTERY 1 YES 2 THO OR DEATH						AILABLE PRIOR TO MPLETION OF CAUSE		
밀	DISEAST.					DEATN?			
ارد	DID TOBACCO USE CONT	RIBUTE TO CAUS	SE OF DEATH	res 🗆	NO UNCERTA	IN 🗆			20 2 _ NO
IA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DE	ATN (Chec	k only one)				
/SI(1 YES 2 NO	HOSPITAL:	R/Outpetient 3 DOA	OTHE	ER: ursing Name 5 - Residence	6 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28e, DATE OF IN. (Month, Day,		IME OF	28c. INJURY AT WORK?	28d. DESCRIBE NOW	INJURY OCCUR	IED	
ΒΥ	1 Netural 5 Pending 2 Accident Investigation			М	1 YES 2 NO				

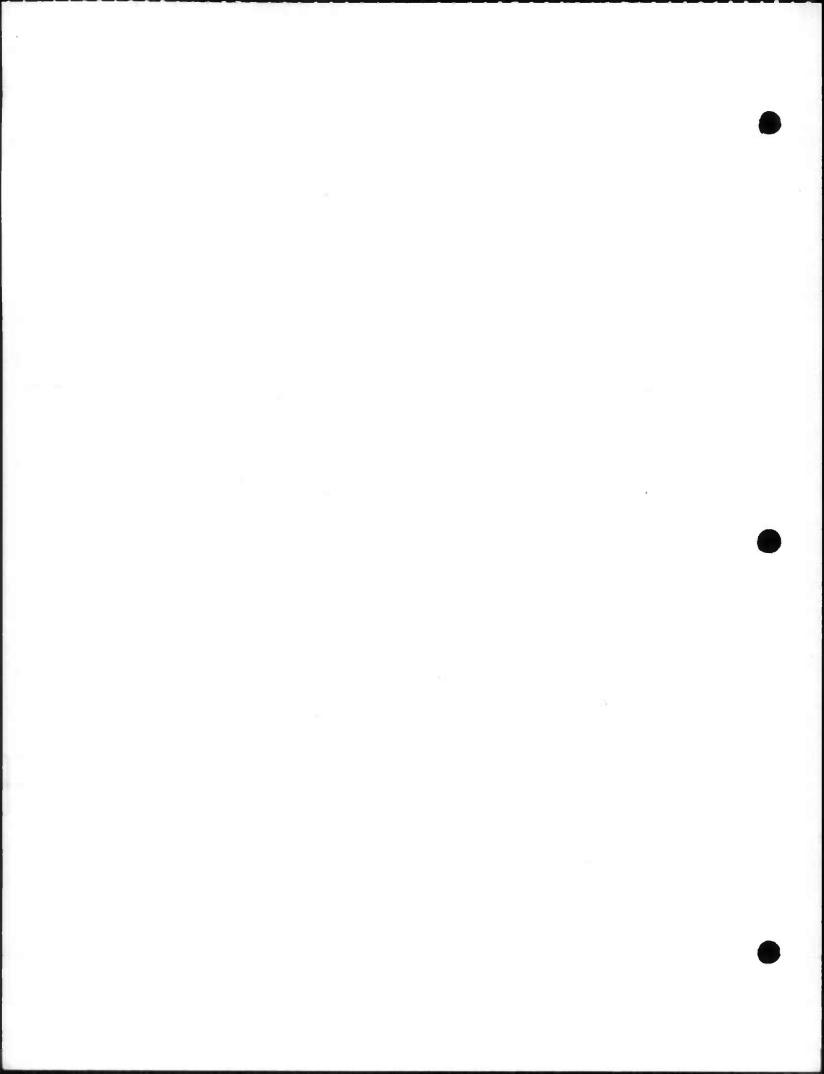
28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 8 Could not be determined 29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 🗌 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end menner ee stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)
2/15/95 29c. LICENSE NUMBER Many Jollia AT2438946

30. NAME AND ADDRESS OF PERSON WND COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MARIO A UNION MEMORIAL HOSPITAL BAITIMORE MARYLAND

31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Savoleon Rardall



2. DATE OF DEATH

3. TIME OF DEATH

FOR STATE REGISTRAR

FEB 1 6 1995

1. DECEDENT'S NAME (First, Middle, Last)

WALTER

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	2 2 - 2 4 - 9 2 F G 7 YRS. MONTHS DAYS HOURS MIN. (Morth, Day, Year) 9e. FACILITY NAME (If not Institution, give strest and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE	RYLAN						
CTOR	HARBOUR HOSP. CENTER, BALTIMORE BALT	IMORE.						
DIRECTOR	MD. BALTIMORE BALTIMORE.	10d. INSIDE CITY LIMITS? 1 YES 2 NO						
FUNERAL	7356 CEISEAVE. 101. ZIP CODE 109. CITIZEN OF W	HAT COUNTRY?						
B	1 Never Married 2 Merried FORCES? 1 DC YES 2 NO If yes, specify Cuban, Maxican, Puerto Rican, atc.) Black,	American Indian, White, etc.						
LETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOTU use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOTU use retired.) MF-CHANIC AJTO REPAIR	2						
at once.	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surrame)	ERS						
TO B	196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 167. DALEWOOD DK. JARRETTS UNE	***********						
r must be	20e. METHOD OF DISPOSITION 1 Suriel 2 Cremation 3 Removal from tale 4 Donation 5 Dither (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Company o							
examine	21. SIGNATURE OF FLIGHTAL SETURCE USERNEE 22. NAME AND ADDRESS OF FACILITY THE DIPUEL F 7/10 BELANEA BALTO. MO 21206	UNETAL K						
int, the medical	23. PART. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reapiratory arrest, shock, or heart fallure. List bely one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Responsively Faulure. (Acute)	Approximeta interval Betw Onset and Do						
TION	Sequentially list conditions, if any, leading to immediate b. Respiratory Due to (or as a consequence or): Due to (or as a consequence or):							
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events reaulting in death) LAST d							
MEDICAL C	PART II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF							
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)	I TYES 2 NO						
PHYSICIAN:	EXAMINER? 1 YES 2 THO HOSTIAL: 1 Princetient 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 Residence 6 Other (Specify)							
BY PH	27. MANNER OF DEATN 1							
ETED	3 Suicide 4 Homicide Solution of the determined Solution of the determined Solution of the determined solution of the determin	ute Number,						
COMPL	29a. CERTIFIER (Check only CERTIFIER) (Check only CE	end manner ee stated						
TO BE	290 STORMUNE MONTHE OF CHESTER ALL STORMER AND STORMER	195 (S						
	ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Pyling) FUNTYMUM 300(5, Hanover St., Baltimore, MD)	21225						

32 MEGISTRAR'S CONASURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

MELLOTT.

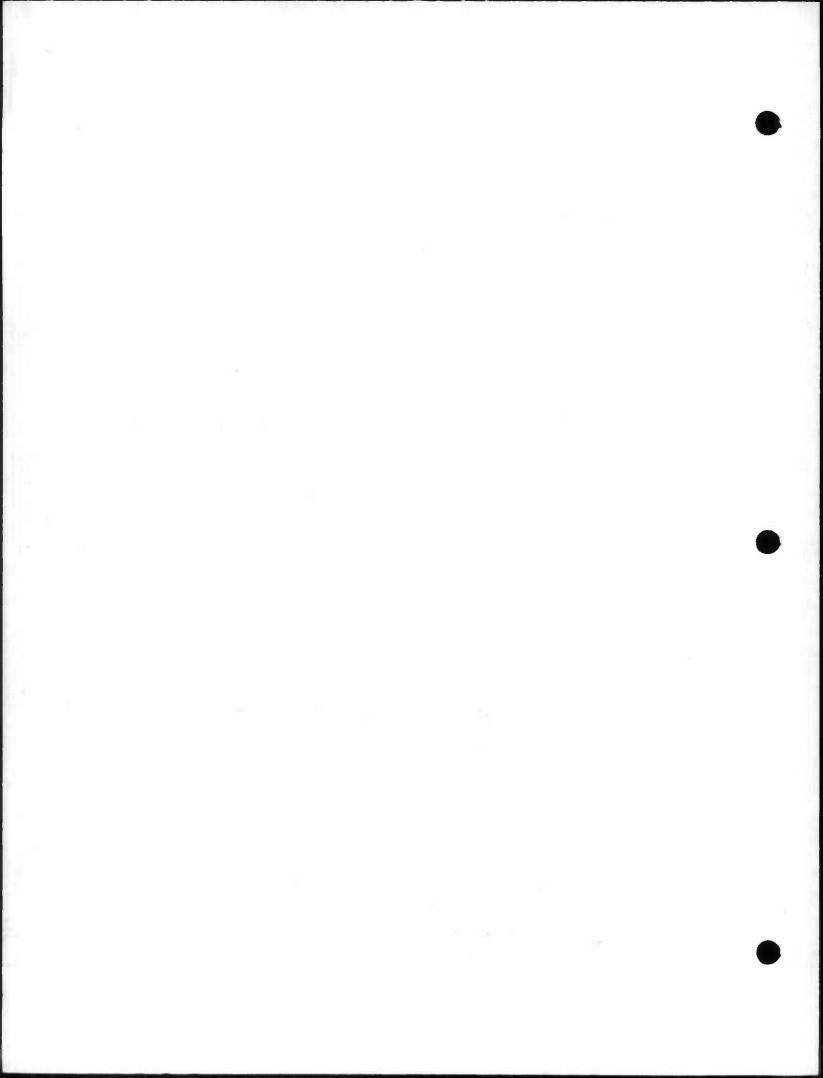
DHMH-16 Rev 1/89

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31. DATE FILEO (Morith, Day, Year) FEB 1 6 1995

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Zella 746 w 02 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year, 1 M 2 X F 213-28-2076 82 November 1 South Carolina use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH University Hospital DIRECTOR Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Md. Baltimore 1) YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1113 S. Carey St. 21223 USA retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married ΒY 3 📝 Widowed 4 🗌 Divorced Black COMPLETED 15. DECEOENT'S EDUCATION 16e. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highes signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for twee and hydrocian and completely filled in by the funeral director, page 5 should be detached for twee any intervent in this man in the first of the first page 5 should be detached for twee any intervent in this man in the first page 5 should be detached for twee any intervent in this page 5 should be detached for the first page Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. FATHER'S NAME (First Middle Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) To Samuel McCullum BE Alice Timmons notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Dwayne M. Burke Shawnee Ct.. Apt. 304. Parkville, Md. 21234 Pe 2/13 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Mt. Zion Cemetery Lansdown. Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral home of Elk., Inc. Main St.. Elkridge. Md. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **IMMEDIATE CAUSE (Finel** the disease or condition_ oronaru UNKNOW reauiting in death) event. DIVISION OF VITAL RECORDS, P.O. BOX 68760 OUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be in FUNERAL DIRECTOR: After this certificate has been signed by the attending physician within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to CAUSE (Disease or Injury other QUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 injury, ' PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE any 1 - YES 2 NO OF DEATH? shows a 1 TES Y NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES PHYSICIAN: NO A 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: | ER/Outpatient 3 DOA OTHER: 4 - Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, OEȘCRIBE NOW INJURY OCCUREO marked, 1 Natural 5 Pending investigation 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 6 Could not be COMPLETED 200 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and ma FUNERAL I 2 MEDICAL EXAMINER: On the be TO THE HOSPITA
TO THE FUNERA
De filed within 7. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. OATE SIGNEO (Month, Day, Year) BE 2 AOORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5 Green 2/201 ague 22 Ul)



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 OBERT 10.211 FEBUM 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreig t - XM 2 - F DAYS HOURS 72 12/17/22 239-26-6668 Union County, N Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN-OR LOCATION OF DEATN 9c. COUNTY OF DEATH SOUTHERN MARYLAND PRINCE GEORGE DIRECTOR HOSPITAL HINTON RESIDENCE OF DE EDENT 10e STATE tob. COUNTY toc. CITY, TOWN OR LOCATION tod. INSIDE CITY MD P.G. Suitland, Maryland TY YES 2 NO permit. F FUNERAL 10e STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? n by the funeral director, page 5 should be detached for use as the bunal-transit permoval 4699 Homer Avenue, #A 20746 U.S.A. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? t YES 2 1 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puarto Rican, atc.)

1 YES 2 N NO Specify: 11 MARITAL STATUS 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 t Never Married 2 X Married BY 3 Widowed 4 Divorced **Black** tea. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b, KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5 +) 8th Tile Setter Self Employed once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Ellison Marsh ESSIE BARRETT MARSH BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MARIE MARSH 1513 Acme Road, Marshville, NC 28103 pe 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION -- City or Town, Stata must Piney Grove Church Cemetery 2 /11/95 Wingate, NC FUHERAL SERVICE LICEN medical examiner Robert G. Mason Funeral Home, Inc. hours after death. #866 1661 Good Hope Road, S.E Wash., DC 20020 IT I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filled in by t haart fallure. List only one cause on each lina. Interval Batween 10 IMMEDIATE CAUSE (Final Onset and Death the disease or condition DUE TO OH AS A CONSEQUENCE OF completely resulting in death) other traumatic event, executed within burial, 2500 CERTIFICATION and Sequantially list conditions, attending physician a if any, leading to immediate certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST 6 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death Mental 23 shows any injury, DIVISION OF VITAL RECORDS, PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. the 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE WAS AN AUTOPSY PERFORMED? MEDICAL signed by t 1 YES 2 NO OF OEATH? t ☐ YES 2 ☐ NO certificate has been h the State Dept. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) item HOSPITAL OTHER: t YES 2 NO Inpatiant 2 - ER/Outpatiant 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) the 6 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 284, DESCRIBE NOW INJURY OCCURED this c marked. t Natural 5 Pending Investigation 1 YES 2 NO BY death After 2 Accident 26a. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 3 Suicide DIRECTOR: A hours after ditem 28 is 6 Could not be COMPLETED 4 Nomicide 29a. CERTIFIER (Check and t CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(s) and manner as stated. THE FUNERAL DE FILE FUNERAL DE FILE WITHIN 72 PK 2
MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED Month, Day, Year BE 9 ERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 32. REGISTRAR'S SIGNATURE 31. DATE FILEO (Month, Day, Year)

MARYLAND 21215-0020 BALTIMORE,

BOX 68760, P.O. I DIVISION OF VITAL RECORDS,

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Moere Christine 12:30 a. 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 4-1-1926 S. BIRTHPLACE (State or Foreign 1 🗌 M 2 屎 F 68 MONTHS DAYS HOURS 22**7-**20-3621 YRS Exmore, VA permit, Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number, 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 2022 St. Paul Street Baltimore, MD 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore, MD MD 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21218 detached for use as the burial-transit 2022 St. Paul Street USA 24 hours after death, Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Mexican, Puerto Ricen, etc.)
1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried Specify: Black B 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life, Do NOT use retired.) Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) Chef Hotel Chain 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) the attending physician and completely filled in by the funeral director, page 5 should be Mental Hygiene prior to burial, cremation, or removal. John W. Brickhouse notified at Mary LeCato BE 190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2022 St. Paul Street, Baltimore, MD 21218 Robert L. Lopem-Layton pe 20e, METHOD OF DISPOSITION
1 Command Service | 2 Cremation | 3 | Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Cemeta) 20c. LOCATION — City or Town, State ROOM 1800 OF AME Church Cometay 2/18 Graysonville, MD must 4 Donetion 5 Other (Specify) H. SIGNATURE OF FUNERAL SERVICE LICENSEP medical examiner 22 NAME AND ADDRESS OF FACILITY ON AVENUE (de Baltimore, MD 21217 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death 神 disease or condition DUE TO (OR ASIA CONSEQUENCE OF): OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 2 event, reaulting in death) tup pecteuro traumatic CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING COLONOLY
DUE TO (OR AS A CONSEQUENCE OFF CAUSE (Disease or injury other i that initiated events resulting in death) LAST 10 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY been signed by the any 1 YES 2 NO OF DEATH? Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate t OTHER:
4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 YES 2 NO I ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c, INJURY AT WORK? marked, this c 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO ВУ After 1 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 00 ETED 8 Could not be OIRECTOR: A 4 Homicide 28 determined Item 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) end manner ea stated. COMPL HOSPITAL (FUNERAL (WITHIN 72 H 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated. TO THE HOSPITA
TO THE FUNERAL
Be filed within 72
IMPORTANT: II 296. SIGNATURE AND TITLE OF CERTIFIER

OF CHARLES OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 126748 MO Da/17/98 2 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BALTO MD 21211 ANIL UBEROI 4419, FALLS FEB 1 6 1995 32. REGISTRAR'S SIGNATURE Talin Sanden Rondolls

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

CERTIFICATE OF DEATH

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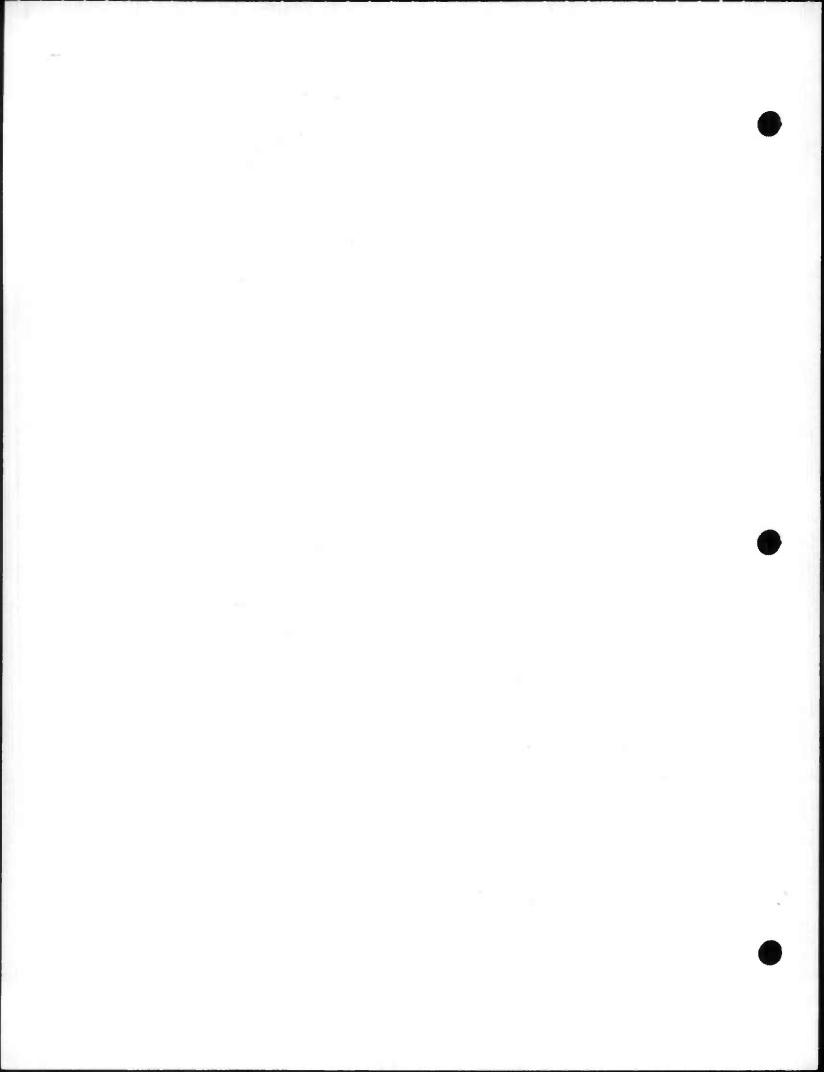
DIVISION OF VITAL RECORDS, P.C

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, remation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF I		MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)	-			7 7	2. DATE OF DEATH MONTH D	AY YEAR	3. TIME OF DEATH		
	ELIZABETH 4. SOCIAL SECURITY NUMBER		1./	FEBRUARY	15. 199					
			(In yrs. last birthday)	IF UNDER 1 YEAR	7. DATE OF BIRTH (Month, Day, Year)	8. BIR Cou	THPLACE (State or Foreign ntry)			
	184-16-4141 9a. FACILITY NAME (If not institution, give str		80 YRS.		HOURS MIN.	May 1, 191		nnsylvania		
00				9b. CITY, TOWN	OR LOCATION OF D	DEATH	9c. COUNTY OF	DEATH		
18	NORTH ARUNDEL HOSE	PITAL ASSOCI	ATION	GLEN	BURNIE		ANNE	ARUNDEL		
DIRECTOR	10a. STATE 10b. COUNTY			TY, TOWH OR LOCA	TION			10d. INSIDE CITY LIMITS?		
	Md. Pr	ince George'	s Bo	wie				t TYES 2 XNO		
FUNERAL		- I - D		10	. ZIP CODE			WHAT COUNTRY?		
N.	11232 Raging Bro	DOK UT. 12. WAS DECEDENT EVER IN	III S ADMED	12 WAS DEC	20720	NIC ORIGIN? (Specify Yes	US			
	1 Never Married 2 Married	FORCES? 1 YES	2 V NO	If yes, sp	ecify Cuban, Maxic	an, Puerto Rican, etc.)	Bla	CE — American Indian, ck, White, etc.		
BY	3 Wildowed 4 Divorced				NO Speci	ry.	Spi	white		
TED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION :ompleted)	(Give kind of	Work done during me		16b. KIND OF BU	SINESS/INDUSTRY			
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 +)	III. Do NOT u			Hoonis	- 1			
MG	17. FATHER'S NAME (First, Middle, Last)		11008	ekeeping		Hospit				
ECC	John Cherkola				The state of the s	Faltin	Sumame)			
00	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a		Route Number, City or Tow	n. State. Zio Code)			
2	Theresa A. Novits	skv	- 1			Bowie.		20		
	20a. METHOD OF DISPOSITION 1\(\subseteq \text{ Burlet} \) 2 \(\subseteq \text{ Cremetion } 3 \subseteq Ramon	val from State	PLACEANDDATE	OF DISPOSITION (N	ime of		CATION City or			
	1\(\) Burial 2 Cremetion 3 Remote 4 Donation 5 Other (Specify)		randview	"Cemeter			hnstown,	Pa. 15905		
	21. SIGNATURE OF FUNERAL SERVICE LICE	J / A			Kaufma	n Funeral	Home of	Flk Inc		
	- Lary o	1. Lough	nery	5695 M	lain St	Flkridge.	Md. 21			
	23. PART I. Entar the diseases, or co shock, or heart tallure. L	emplications that coused lat only one couse on a	tha daath. Do	not entar tha mo	da of dying, au	ch as cardiac or respi	ratory arreat,	Approximate Interval Batween		
	IMMEDIATE CAUSE (Final disease or condition									
	reaulting in desth)	DUE TO OR AS A	COMPENSION OF	pulm						
-		(100-	Obshr	him	lun	1				
흔	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O			0				
S	cause, Entar UNDERLYING CAUSE (Disease or Injury	Confest	in Le	uf	faitu					
E	that initiated events resulting in daeth) LAST	DUE TO (OR AS A	CONSEQUENCE O		100-1	neistra	1 R			
CERTIFICATION	d.	AUNH	RINNIA	- Cuth	ryun	Vu.u,VI.u		/		
AL	PART II. Other algnificant conditions	contributing to daeth b						b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
MEDIC	Severed	Left Si	Carofiel	arte	y rep	1 TES 2		COMPLETION DF CAUSE OF DEATH?		
M M					<i>/ '</i>			1 TYES 2 NO		
PHYSICIAN:	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL		F DEATH YI	S X NO [UNCERTAI	N 🗆 📗				
딣	EXAMINER?	HOSPITAL:		OTHER:	_0490/5					
Ě	27. MANNER OF DEATH	1 Inpatient 2 ER/Outp	28b. TIN			8 Other (Specify) 28d. DESCRIBE HOW I	NURY OCCUPED			
	Natural 5 Pending	(Month, Day, Year)		JURY WO	RK7 (ES 2 NO					
D BY	2 Accident Investigation 3 Suicide 8 Could not be	28s. PLACE OF INJURY building, stc. (Spec	— At home, tarm,	street, factory, offic		281. LOCATION (Street a	and Number or Rural	Route Number,		
	4 Homicide determined	building, arc. (Spec	ay)			City or Town, State)				
COMPLETED	29a. CERTIFIER (Check only	IAN: To the best of my knowl	edge, death occurr	ed at the time, data	and place, and due	to the cause(a) and mar	nner as stated,			
OM		: On the basis of examination						(a) and manner as stated,		
l w l	29b. SIGNATURE AND TITLE OF CERTIFIER	my,	1	/	29c. LICENSE NU	MBER	29d. DATE SIGNE	D (Month, Day, Year)		
TO B		///	L.	m	1) 25	654	1/15	195		
-	36. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAMES OF OF	ATH (ITEM 27) (Type	Print	-/		1			
	YEONG H OH M D 31. DATE FILED (Month, Day, Year)	1/12 CRAIN	HIGHWAY	,N #6A,	GI EN BUE	NIF, MARYL	AND 210	61		
1 1	FEB 1 6 1995 74	LA COMPANION NO	delle							

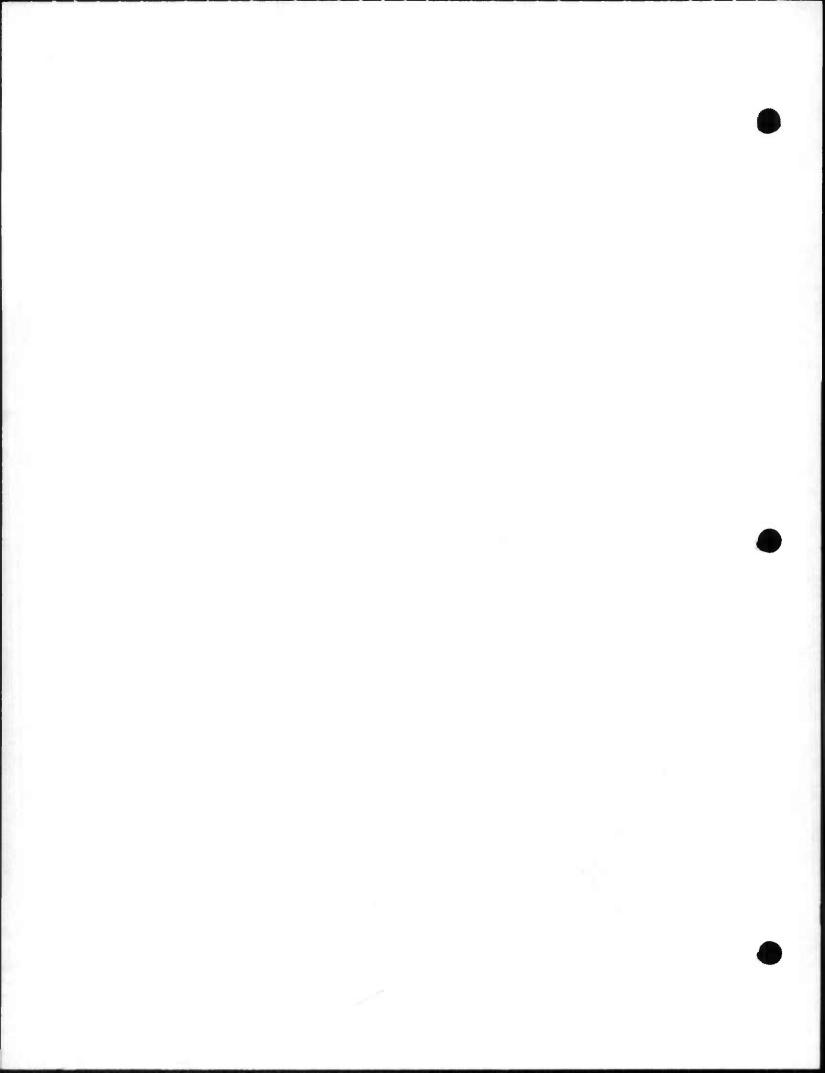


BALTIMORE, MARYLAND 21215-0020

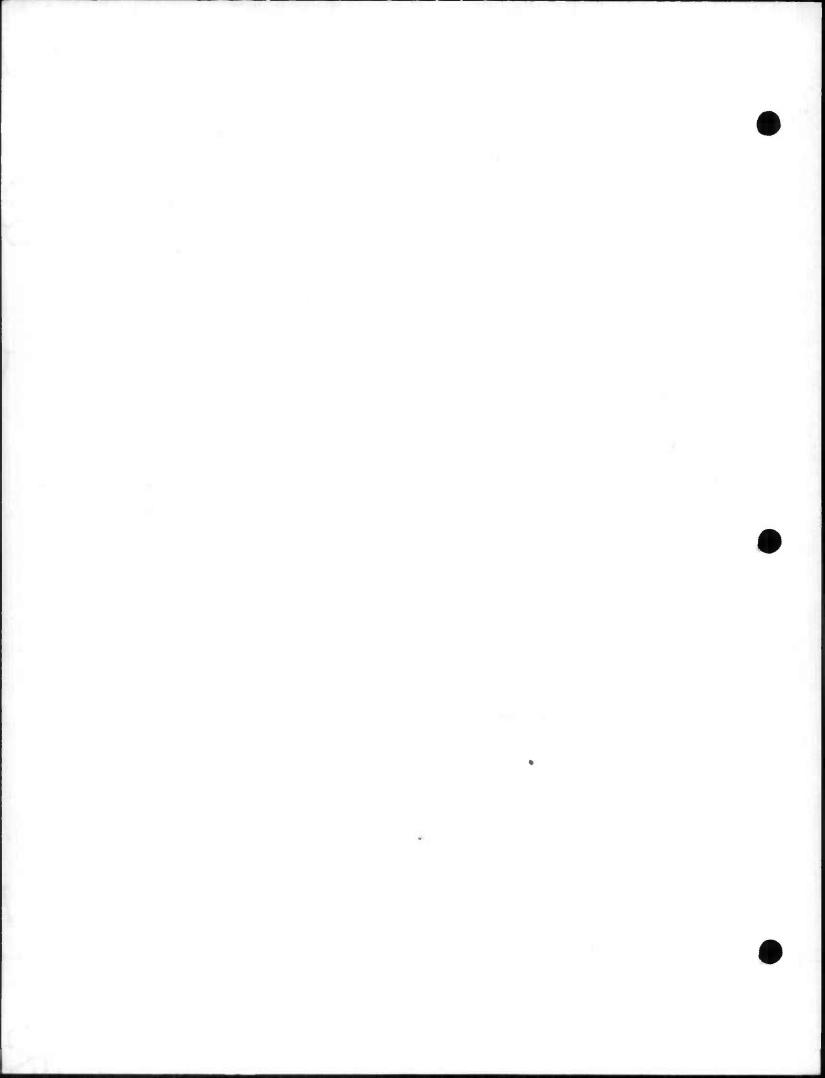
DIVISION OF VITAL RECORDS, P.O. BOX 68760

EMPTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the executed with after death, Page 6 may be retained by the hospital or attending physician.	DRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should min at hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	NT. If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
IAL OR ATTENDING PHYSICIAN: The law requires that	AL DIRECTOR: After this certificate has been signed by nours after death with the State Dept. of Health and	If item 28 is marked, or item 23 shows any

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND	MENTAL HYGI				
	1. DECEDENT'S NAME (First, Middle, Last	0				2. DATE OF DEAT	1		3. TIME OF DE	EATN
	JULIA MAE	NICHOLS				2/10/19		YEAR	11:30	P.M.M
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (I. BIRTH	IPLACE (State of	
	579-24-9100 90. FACILITY NAME (If not institution, give	1 M 2 XF 73	YRS.	DAYS	HOURS MIN.	(Month, Day, Yea 7/25/19	7)	VIRO	GINIA	
DIRECTOR	GOOD SAMARITAN NU			BALTIM		LAIN .	Sc. Cooki	Y OF U	CAIN	
<u> </u>	10a. STATE 10b. COUN	TY	10c. CITY, 1	TOWN OR LOCAT	ION				10d. INSIDE C	ITY
뜽	MARYLAND		ВАТ.Т	IMORE				- 1	LIMITS?	
	10a. STREET AND NUMBER		Dillo:		. ZIP CODE		10g, CITIZE	EN OF V	WHAT COUNTRY	
FUNERAL	2037 WHEELER AVE	₹.		2	1216		USA			
2 5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED			NIC ORIGIN? (Specify		4. RACE	— American Ir	dian
	1 Never Married 2 Married	FORCES? 1 YES		If yes, sp	ecify Cuban, Maxica 2 X NO Specif	in, Puarto Rican, atc.		Black Speci	c, White, atc.	,
B	3 Widowed 4 Divorced			1	- A chack	y.		ARF		CAN
	15. DECEDENT'S ED (Specify only highest grad	UCATION de completed)	16a. DECEDENT'S US	UAL OCCUPATIO	ON st of unching	16b. KIND OF	BUSINESS/INDU	STRY		
	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use n	etired.)	at or working	SOCIA	SECUR	ITY	ADMIIN	ISTRA
<u> </u>	12	4	teacher			BALTI	MORE CIT	ГΥ		
COMPL	17. FATNER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Mai	den Surname)			
BE	THORNTON	DUNCAN			EVE	LYN DUNG	CAN			
0	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AC	DRESS (Street a	nd Number or Rural	Route Number, City or		ode)		
F	HOWARD W. NICHO	DLS	2037 V	VHEELER	AVE, BA	LTIMORE,	MARYLA	ND 2	21216	
	20a. METNOD OF DISPOSITION 1 V Buriel 2 Cremation 3 Rec		PLACE AND DATE OF		me of	OATE 20c	LOCATION - CI	ty or To	wn, Stata	
	4 Donation 5 Other (Specify)	GA	${ m ARRISON}$ FC	REST C	EMETERY	2/15/95	OWINGS I	MILI	L, MD.	
	21. SIGNATURE OF FUNERAL SERVICE L	CENSE			D AOORESS OF FA					
- 8	MThe I	100	11			S FUNERA				. 1
	23. PART I. Enter the diseases, or	complications that caused	the death Do not	1300	EUTAW PL	ACE, BAL	TIMORE,	MD		
	shock, or heart failure	. List only one cause on ea	ich line.	enter the mo-	ge of dying, suc	n aa cardiac or re	apiratory arres	it,	Approxi	mate Between
	IMMEDIATE CAUSE (Fine) disease or condition								Onset a	nd Death
	resulting in death)	a. //www.	CONSEQUENCE OF:						24	to.
		DUE TO (OR AS A)	CONSEQUENCE OF):	Par	Vinto	nis B	10.	,	/	
5	Sequentielly list conditions,	DUE TO (OR AS A	CONSEQUENCE OF:	1000	CINTO	700 91	sense		611	10-
HIFICATION	If any, leeding to immediate cause. Enter UNDERLYING	000 10 (011 AD A	consequence or).						i	
	CAUSE (Disease or Injury that Initiated events	C. DUE TO (OR AS A	CONSEQUENCE OF):						-	
=	resulting in death) LAST	Va.	111111111111111111111111111111111111111						j	
5		d							+	
4	PART II. Other algnificent condition	ons contributing to death bu	ut not resulting in t	the underlying	cause given in		AN AUTOPSY	24b.	WERE AUTOPSY	
							FORMED?		AWAILABLE PRIC	
MEDIC									OF DEATH?	I NO
	DID TOBACCO USE CONT	TRIBUTE TO CAUSE OF	F DEATH YES		UNCERTAIN	V []			. [] [
HISICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (
5	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpa		THER:	5 🗆 Residence	8 Other (Specify)				
	27. MANNER OF DEATN	28a. DATE OF INJURY	28b. TIME O	F 28c. INJ	JRY AT	28d. DESCRIBE HO	W INJURY OCCU	REO		
-	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR		ES 2 NO					
	3 Suicide s Could not be	28a PLACE OF IN ILIBY	- At home, farm, street	et, factory, office		281. LOCATION (Stre	et and Number or	Rural R	loute Number,	
4	4 Homicide determined	ounding, are. (Special	''			City or Yown, St	nte)			
٤	29a. CERTIFIER 1X CERTIFYING PNYS	SICIAN: To the beat of my knowle	edge death occurred a	t the time date	and place, and due	to the neurote's and	uconsuo.m			
Ē		IER: On the besis of axamination							and manner are	etera d
5	290. SIGNATURE AND TITLE OF CERTIFIE									
	11/10				29c. LICENSE NUN		29d. DATE S	HGNED	(Month, Day, Yes	r)
2	30 NAME AND ADDRESS OF PERSON W	HO COMPLETED CALLES OF ST	THE STREET		200	77/	1 d	-/	1 -7	,
	5601- hor	L Raver	IS O	The state of the s	Ba	15)mire	MB	2	1239	7
31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE										



		REGISTRAR		CERTIF	ICATE OF	F DEATH	REG. NO						
		1. DECEDENT'S NAME (First, Middle, Last)	Helen Nem	necek			2. DATE OF DEATH MONTH Feb. 14.	î'995	3. TIME OF DEATH 6:20 A. M				
		4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign				
		212 00 6722	104086		MONTHS DAYS		Nov. 1,19		Mary land				
pino		213-09-6732 9a. FACILITY NAME (If not institution, give s		78 THS.	95 CITY TOWN	OR LOCATION OF DE		9c. COUNTY					
3 should	œ						SAIN .	1					
1, 2,	DIRECTOR	Harbor Hospital	Lenter		Balti	more		Balt.	imore City				
	ĕ	10a. STATE 10b. COUNT		10c. Cl	TY, TOWN OR LOC	ATION			10d. INSIDE CITY				
2	5	Maryland		E	altimor	· A			LIMITS?				
permit. Pages	A	10e. STREET AND NUMBER			101. ZIP CODE	OF WHAT COUNTRY?							
asit.	FUNERAL	1516 Sycamore S			21226		Unite	ed States					
020 physictan. burtal-transit	5	11. MARITAL STATUS	12. WAS DECEDENT EVER		13. WAS DE	ECENDENT OF HISPAN	IIC ORIGIN? (Specify Ye		BACE - American Indian				
Phy Duri		1 Never Married 2 Married	2 MNO DATES		specify Cuban, Maxica ES 2 X NO Specify			Specify: White atc.					
215-0020 attending physician se as the burlal-tra	ВУ	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 2 NO Specify:											
atter	ED	15. DECEDENT'S EDU (Specify only highest grade		(Give kind of	Work done during r	TION most of working	166. KIND OF BU						
YLAND 2121 by the hospital or att be detached for use at once.		Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	ise retired.)		- 1						
ched ched	₹ I	12	0	Bea	utician		0wn	Shop					
YLAND 2 by the hospital be detached to at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)					
d by d by	BE	Alois	Nemecek			Sophi	a	Klemer	nt				
MARYLAND 21215-0020 retained by the hospital or attending physics should be detached for use as the burial notified at once.	9	19a. INFORMANT'S NAME (Type/Print)		19b. MAILIN	ADDRESS (Street	t and Number or Rural i	Route Number, City or Tox	m, State, Zip Co	de)				
	-	Gerald Soukup		4305 9	oth Ave	. Baltimo	ore Maryla	nd 2:	1236				
ORE office, pa		20a. METHOD OF DISPOSITION 1		b. PLACE AND DATE		Name of	DATE 20c. LC	CATION — City	or Town, State				
Page 6 at directs mer mu	8 0	4 Donation 5 Other (Specify)		Holy Cro	iss Cem.			ooklyn	Park, Md.				
ALTIM death. Page tuneral dee tuneral dee		E. Ecker 22. NAME AND ADDRESS OF FACILITY											
B		▶ X(//			McCu	illy Funer	al Home		·				
# 15 E		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory stress, approximate shock, or heart fediure. Liet only one cause on each line.											
		The second secon	Liet Dnly Dne cause Dn	eech line.					Interval Between Onset end Death				
by filled attion, or	l	disease or condition											
760, ed within 24 ompletely fille ompletely fille cremation, event, the		resulting in death)	DUE TO (OR AS	A CONSEQUENCE	SHUCK								
P 5 - 6	z		Acuto	MUDCAS	dial 1	nfractio	n		ĺ				
OX 68: e be execute sician and connor to bunia traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST b. Acute myocardial infraction DUE TO (OR AS A CONSEQUENCE OF): Chronic Ischemic tleart disease DUE TO (OR AS A CONSEQUENCE OF):											
O ate by prior tra	S												
P.O. B uth certificat tending phys al Hygiene p or other	E												
e # pe pe pe	Ä	resulting in death) LAST	d										
CORDS, Free tree that the death signed by the atter lealth and Mental we any injury, or any injury, or		PART II. Other eignificant condition	ne contributing to deeth	but npt resulting	in the underlyi	ing cause given in	Part I. 24a, WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS				
ORC that the	EDICAL	Diybetes meli				onic renu	PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE				
O 8 5 5 6		C 1 62	1	, , , , , , , , , , , , , , , , , , , ,	,	7,110	1 🗆 YES :	5 (TINO	OF DEATH?				
REC requires seen sign of Heal	Σ	DID TOBACCO USE	CONTRIBUTE TO	CAUSE OF	DEATH	YES NO			1 TES 2 NO				
AL RE le law req has been Dept. of 1 23 she	A	25. WAS CASE REFERRED TO MEDICAL		0.1002 01		PLACE OF DEATH (Ch							
DIVISION OF VITAL RE(OR ATTENDING PHYSICIAN: The Law required DIRECTOR After this certificate has been showns after death with the State Dept. of H Item 28 is marked, or frem 23 show	PHYSICIAN: M	EXAMINER?	HOSPITAL:	Inetient 3 DOA	OTHER:	ome 5 🗆 Residence							
SICIAN Certific the	Ě	27. MANNER OF DEATH	28a. DATE OF INJURY			NJURY AT	26d. DESCRIBE HOW	INJURY OCCUR)FD				
ION OF Alber this or cleath with is marked,	150	1 Natural 5 Pending	(Month, Day, Year)	- IN	JURY W	VORK?							
O O O O O O O O O O O O O O O O O O O	B	2 Accident Investigation 3 Suicide & Could not be	28s. PLACE OF INJUR	Y — At home, ferm,			28f. LOCATION (Street	and Number or	Rural Route Number.				
S Page 28	Ħ	4 Homicide 6 Could not be	building, atc. (Spe	ecify)			City or Town, State,		,				
DIVISION OR ATTENDING DIRECTOR After hours after deatt	COMPLETED	29a. CERTIFIER	ICIAN, To the heat of my line	de de la de									
E ZZ	₹		ICIAN: To the best of my know						ause(a) and manner as stated.				
78 EE		29b. SIGNATURE AND FITLE OF CERTIFIE		on anator investigate	on, army opinion,								
E E	出	298. SIGNATURE AND TITLE OF CERTIFIES	M.D.			29c. LICENSE NUM		29d. DATE SI	IGNED (Month, Day, Year)				
6 5 8	2	30 NAME AND ADDRESS OF PERSON WIL		EATH (ITEM OF CT	Onlest)	17224	4161436	1	14/95				
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
107	~		1	FLEFTI	1FPIA	DIS							
		Harbor Hospital	Center /	FLEFTI	IERIA	DIS			_				
		Harbor Hospital	1	MATHER	IERIA	DIS							



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BALTIMORE, MARYLAND 21215-0020	2906
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A	dea
8	AN: The law requires that the death certificate be executed within 4 hours after death. Place 6 may be retained by the hospital or attending on
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	BR

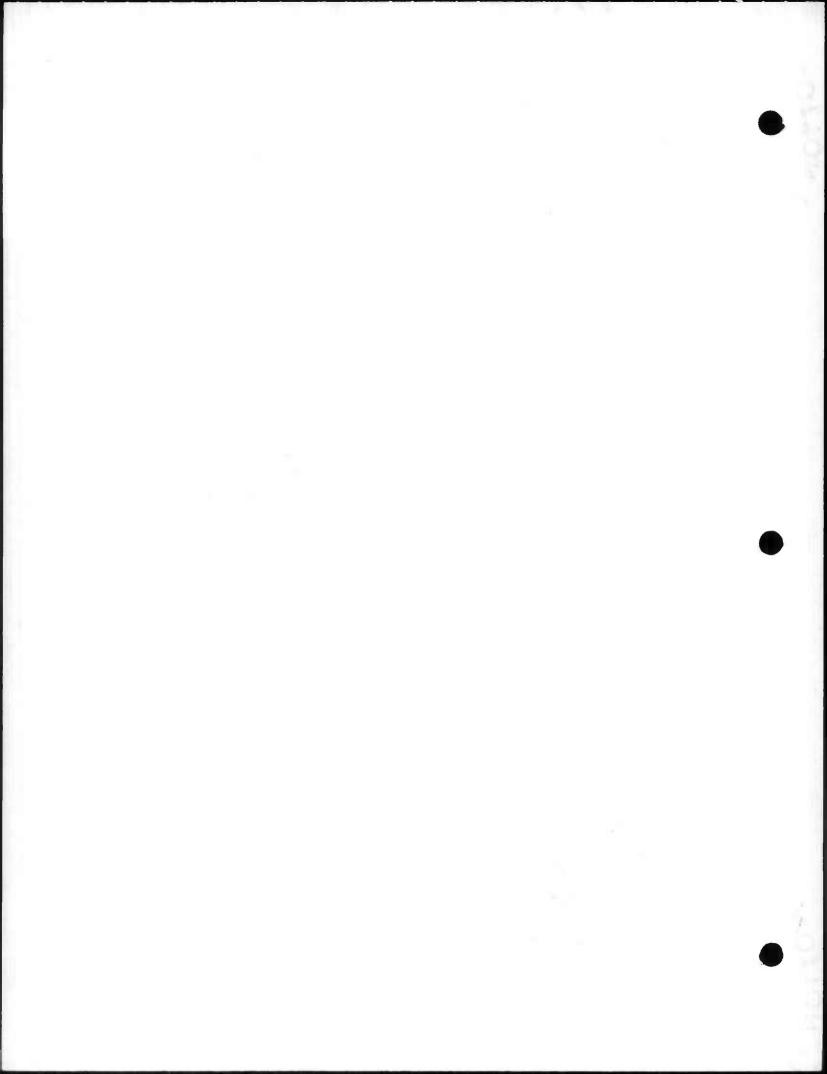
TO THE HOSPINAL PRATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEIN DISCRIPTE After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Note: 28 is prarked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	Middle, Last)						DEA		2. DATE OF DEATH			3. TIME OF DEATH
	Karolina Neumeister									February	w _{13 1}	07548	2:00 P
	4. SOCIAL SECURITY NUMBER	IER	5. SEX	6. AGE (In yrs. I		IF UNDER	Vran	IF UNDER		7. DATE OF BIRTH	13,1		
	219-32-343	6	1 □ M XX F		YRS.	MONTHS	DAYA	HOURS	MIN.	(Month, Day, Year)		Country	
	9a, FACILITY NAME (If not in	-		76		01.000	. =====			Jan.23,1			
Œ				L . 1		90. CITY			ON OF DE			INTY OF DE	
DIRECTOR	Franklin S	EDENT	HOSP1	cal			Ro	SSV	ille	9	Bal	ltimo	re
E C	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION					10d, INSIDE CITY
100	Maryland	Ва	ltimor	9		Ī	SSS	X	_			- 1	LIMITS?
AL	10a. STREET AND NUMBER						101	ZIP COD	E		10g. CIT	IZEN OF W	HAT COUNTRY?
ER	1577 Willi	ams A	venue					21	221		_	.S.A	
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN			13.	WAS DEC	ENDENT C	OF HISPAN	IC ORIGIN? (Specify Yea			— Amarican Indian,
BYF	1 Never Married 2 3 Widowed 4 Dive		IF YES, GIVE V	YES 2-12 WAR OR DATES	ОМС				n, Mexicar Specify	n, Puerto Rican, etc.)		Black, Specif	, White, etc.
								2001				3,500	White
買		EDENT'S EDUC highest grade			ECEDENT'S	work done -			na	16b. KIND OF BUS	INESS/IN	DUSTRY	
	Elementary/Secondary (0	-12)	College (1-4 or 5	F)	6. Do NOT u					93.			
COMPLETED	12				Seam	stre	SS		_	Clot		g	
	17. FATHER'S NAME (First, M.									WE (First, Middle, Maiden			
BE	Franz Mun								nna				
2										loute Number, City or Town			
	Greta Bun 200. METHOD OF OISPOSITI			1	/36 (Cott	onw	ood	Dr.	Severna			
	1 St Buriel 2 Cremetto 4 Donatton 5 Other	n 3 🗆 Remo	vet from State	Cometery, C	AND DATE	ther place)	OK 1 3	me of	5~	2/17/95Bal	CATION —	City or Tov	vn, State
1	21. SIGNATURE OF FUNERAL	,	ENGEE	HOLLY	11111	122	NAME AN	T Ga	SS OF FAC	4/1//95Bal	LO.	CO.,	waryland
	• ()	12	0	1		Br	uzda	zinsl	ςi Fι	ineral Home	e P.A	Α.	
_	Te	13	200	>	_	14	107 I	Easte	ern A	Ave Baltim	ore,	Md 2	1221
	23. PART Enter the di shock, or he	seases, or c eart failure. I	omplications the lat only one cau	t cadsed the d	leath. Do r ie.	ot enter	the mo	de of dy	ing, auch	as cardiac or respir	ratory an	reat,	Approximate interval Between
ļ	IMMEDIATE CAUSE (Fin		1										Onset and Death
	disease or condition resulting in death)	→				r (bone and liver)						4 months	
			Breast	OR AS A CONS	EOUENCE O	F):							20years
S	Sequentially ilst conditi	ons,	l	(OR AS A CONSI									Zoyears
CERTIFICATION	If any, leading to immediate. Enter UNDERLY!		Multi-o										5 days
윤	CAUSE (Disease or Inju			(OR AS A CONSI									Juays
Ē	resulting in death) LAS	r		(,-							
핑			•		_								
A	PART ii. Other signification	nt conditions	contributing to	death but not	reaulting	n the un	derlying	cause g	given in i	Part i. 24s. WAS AN / PERFORI			WERE AUTOPSY FINDINGS
EDICAL										1 - YES 3			AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
M													1 TYES 2 NO
	DID TOBACCO U	SE CONTR	IBUTE TO CA	USE OF DEA	ATH YE	S 🗆 I	(集 0)	UNC	ERTAIN				
SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26. PL/	CE OF DEAT		, , ,						
ıs I	1 TYES 2 XNO		1 1 Inpatient 2	ER/Outpatient	3 🗆 DOA	4 Nun		5 🗆 Re	sidence (6 Other (Specify)			
ĎH A	27. MANNER OF DEATH	no de	26e. DATE OF (Month, D.		29b. TIM INJ	E OF URY	28c. INJU			26d. DESCRIBE HOW IN	JURY OC	CURED	
à l		Pending nvestigation				М		ES 2 [NO				
		Could not be	26s. PLACE O building,	F INJURY — At h etc. (Specify)	ome, ferm, a	itreat, fact	ory, office			26f. LOCATION (Street as City or Town, State)	nd Number	or Rurel Ad	oute Number,
<u>.</u>													
COMPLET	(Check only	FYING PHYSIC	IAN: To the best of	my knowledge, d	eath occurre	d at the ti	me, data	and place,	and due t	to the cause(a) and man	ner an atat	ted.	
8	one) 2 MEDIO	CAL EXAMINER	: On the beals of a	amination and/or	Investigatio	n, In my o	pinion, de	ath occur	ed at the t	ime, data and place, and	due to th	e cause(a)	and menner as stated.
iu III	296 SIGNATURE AND TITLE	OF CERTIFIER	11	//		4.40	<u> </u>	29c. LICE	NSE NUM	BER	29d. DAT	E SIGNED (Month Day, Year)
		7	1014	you		MI	ا ،	RD	175	7	1 7	2/13	3/95
임	30, NAME AND ADDRESS OF	PERDON WHO	COMPLETED CAUS	OF DEATH (IT	Туре,	Print)	-					1000	/
	Dr. Robert		rre 9000	Frankl	in Sq	uare	Dr.	Bal	t1mo	re, Maryla	ind 2	1237	ı
	FEB 16 19	ios d	J2. AEGISTRA	R'S SIGNATURE	,								
	10 10	00	The state of the s	w amount									



BALTIMORE, MARYLAND 21215-0020

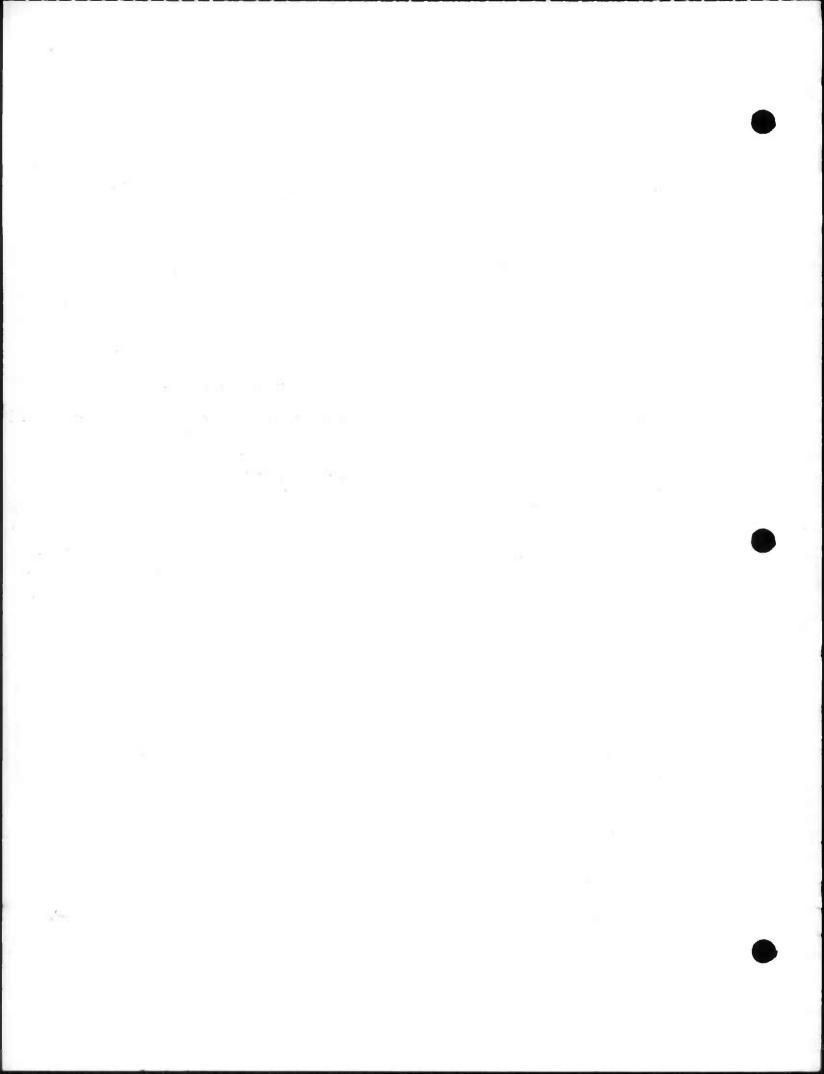
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within, frours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	TATE OF MARYLAN	D / DEPAR CERTIF	TMENT OF	HEALTH AND	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH DA		3. TIME OF DEATH
	Grant L	Poe				February 1		
	4. SOCIAL SECURITY NUMBER 5. SE		rs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
	577-74-3936 1 X	M 2 🗆 F	53 YRS.			December 12.	The second second	Vashington, DC
Œ		a number)			OR LOCATION OF D	EATH	9c. COUNTY	OF DEATH
1 25	1317 W. Pratt St.			Baltimo	ore			
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS?
	Md.		B:	altimore				1 X YES 2 NO
RA	1317 W. Pratt St.			16	H. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?
FUNERAL	11. MARITAL STATUS 12 W	MAS DECEDENT EVER IN U.S	S. ARMED	13. WAS DE	21223 CENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No — 14	USA RACE — American Indian,
BY F	1 Never Married 2 X Married IF	ORCES? 1 YES 2	X NO	If yes, s	pecify Cuban, Maxica 3 2 NO Specific	en, Puerto Rican, etc.)		Black, White, atc.
ED B								white
ETE	15. DECEDENT'S EDUCATION (Specify only highest grade comple Elementary/Secondary (0-12) Colk	Hed)	(Give kind of w life. Do NOT us	USUAL OCCUPATI ork done during m o retired.)	ON ost of working	16b. KIND OF BUS	SINESS/INDUS	TRY
딜	10	ege (1-4 or 5 +)	Pain	ter				
COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Maiden	Surname)	
BE (Henry Poe					ice Anderso		
0	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Town		ode)
	Kimberly M. Poe					Balto., Md.		
1	1 Burial 2 Cremation 3 Ramoval In	om State cemeter	y, crematory or oti					y or Town, State
- 9	21. SIGNATURE OF FUNEAAL SERVICE LICENSPE) , line	Green	22. NAME A	emetery	2/15 Ba	100.,	MQ.
- 3	· Lay L.	Koufm	eny	5695	Main St	Flkridge	Md	of Elk., Inc.
	23. PART I. Enter the diseases, or compil ahock, or heart tallure. List of	cetions that coused the	e death. Do n	ot enter the mo	ode of dying, suc	h as cardiec or respi	ratory arres	Approximate interval Between
	IMMEDIATE CAUSE (Final			1				Onset and Death
	resulting in death) a	Metastati	NSEGNENCE OF	creation	- can	cer		Z months
z		222 10 (011 10 11 00)	TOLOGETOL OF	,.				
CERTIFICATION	Sequantielly list conditions, if any, leading to immediate	DUE TO (OR AS A CO	NSEQUENCE OF):				
2	CAUSE (Disease or Injury	DUE TO (00 40 4 00)						
	that initiated events resulting in death) LAST	DUE TO (OR AS A COI	NSECUENCE OF):				
S	d							
AL	PART II. Other algnificent conditions conf	iributing to deeth but n	not resulting li	the underlyin	g cause given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
MEDIC						1 - YES 2	NO	OF DEATH?
X	DID TOBACCO USE CONTRIBUT	TE TO CALISE OF F	EATU VE		LINICEDTAN	/		1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			H (Check only one)		N L I		
SIC		SPITAL: Inpatient 2 ER/Outpatier		OTHER:	1	6 Other (Specify)		
λ H ζ	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. IN.	IURY AT	28d. DESCRIBE HOW IP	JURY OCCUR	ED
ВУ	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO			
	3 Suicide a Could not be 4 Homicide detarmined	28s. PLACE OF INJURY — A building, etc. (Specify)	Al home, ferm, st	reet, factory, offic		28I. LOCATION (Street a City or Town, State)	nd Number or	Rural Route Number,
Ē								
COMPLETED	(Check only CERTIFYING PHYSICIAN: I							
	2 MEDICAL EXAMINER: On 1	THE DESIGN OF EXERTIMATION SIX	2 or investigation	i, in my opinion, c				
BE	Barbara a C	onlus	MA		29c. LICENSE NUI	1794	29d. DATE SI	GNED (Month, Day, Year)
유	30. NAME AND ADDRESS OF PERSON WHO COMI	PLETED CAUSE OF DEATH	(ITEM 27) (Type,	Print)	0 11	more 1	40	.5-73
	31. DATE FILED (Month, Day, Year)	South (Treen	e >t	Dalti	more n	יטר	21201
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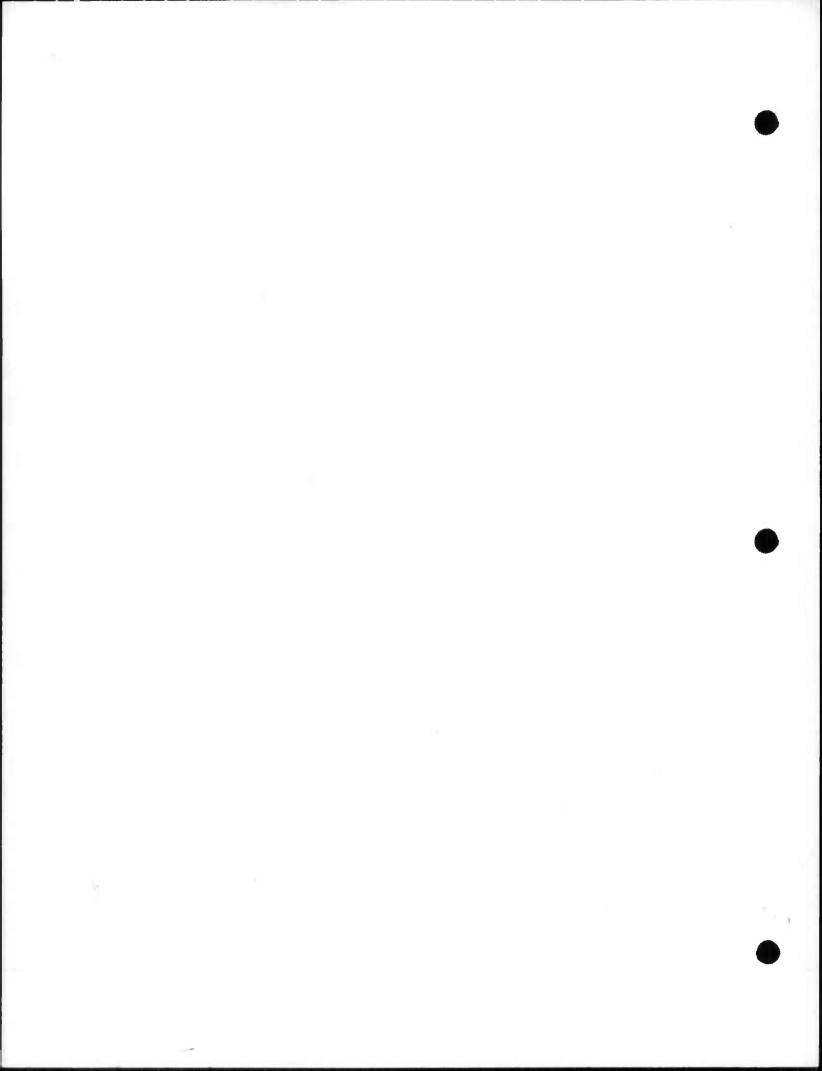
		1 - STATE OF MARYLAND REGISTRAR	/ DEPARTMENT OF CERTIFICATE O		ENTAL HYGIENE REG. NO.	
		1. DECEDENT'S NAME (First, Middle, Last) 4. SOCIAL SECURITY NUMBER 5. SEX 1 🗓 M 2 🖂 F 33	MONTHS DAY	R IF UNDER 24 HRS.	2. DATE OF DEATH DAY 1. DATE OF BIRTH (Month, Day, Year)	3. TIME OF DEATH S. BIRTHPLACE (State or Foreign
. 2, 3 should	стов	9a. FACILITY NAME (If not institution, give street and number) Joseph Richey Hospice RESIDENCE OF DECEDENT	9b. CITY, TOW	n or location of dear more, Md.	9/18/61	Wichita, Ks. c. COUNTY OF DEATH Baltimore County
permit. Pages 1,	RAL DIREC	MD Baltimore 10s. STATE 10b. COUNTY MD Baltimore	Baltimor		10	10d. INSIDE CITY LIMITS? 1 TYPES 2 NO DOG: CITIZEN OF WHAT COUNTRY?
020 physician. buńal-transit	BY FUNER	4313 Marble Hall Road 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. FORCES? 1 A YES 2 IF YES, GIVE WAR OR DATES	NO If yes,	DECENDENT OF HISPANIC specific Cuban, Maxican, YES 2 NO Specify:	No- 14. RACE — American Indian, Black, White, atc. Specify: Black	
21215 al or attend for use as	ETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	DECEDENT'S USUAL OCCUPA (Give kind of work done during Whe. Do NOT use retired.) Organist	ATION most of working	16b. KIND OF BUSINE	Hill Pres. Ch.
ed by	BE COMPL	17. FATHER'S NAME (First, Middle, Last) John J. Pyles	19b. MAILING ADDRESS (Street	Deborah	Thompson E	Pyles
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ALTIN death. Pag funeral dir funeral dir examiner		21. SIGNAZAME OF PORTURAL SERVICE LICENSEE	166	1 Good Hop	on Funeral e Road, S.F	Home, Inc. E., DC 20020
ours y filled in the ation, or re-		23. PART I whiter the diseases, or complications that plused the shock, or heart failure. List only one cause on each limited the cause (Final disease or condition resulting in death)	ine.		na cerdiac or reapirato	Approximate Interval Between Onset and Death
ath certificate be executed tending physician and com all Hygiene prior to burial, or other traumattic expenses.	CERTIFICATION	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST		etion		8mon
signed by the Health and M	MEDICAL C	PART II. Other eignificant conditions contributing to death but not	t resulting in the underly	ing ceuse given in Pa	PERFORMED 1 YES 2	D? AMAILABLE PRIOR TO
The law fe has b ate Dept.	SICIAN:	EXAMINER? 1 VES 2 A0 HOSPITAL: 1 Inpetient 2 ER/Outpatient	ACE OF DEATH (Check only or OTHER: 3 DOA 4 Nursing H	ne)	Other (Specify) R	cher Hesuice
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TO THE HOSPITAL OR ATTEN TO THE FUNERAL DIRECTOR: De filed within 72 hours after IMPORTANT: It teem 28 is	COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, one) 2 MEDICAL EXAMINES: On the basis of examination and/o				
TO THE P TO THE P De filed w	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER M. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IT		1300 6	•	d. DATE SIGNED (Month, Day, Year) 12 (-2 5 95
		31. DATE FILED (Morith, Day, Vear) FEB 1 6 1995 July Davidsor Revolution		cad St	Bet	4inon-12



DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE

		REGISTRAR		CEI	THE	AIE UF	DEATH	1	REG. NO.		
		1. DECEDENT'B NAME (First, Middle, Last)						12	. DATE OF DEATN		3. TIME OF DEATN
		Theodore Vict	or Rake	owski				Fe	ebruary 1	0,1995	EAR M
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AG	E (In yrs. lest b	irthday) II	F UNDER 1 YEAR	IF UNDER 24 H	-	DATE OF BIRTH		BIRTHPLACE (State or Foreign
		214 16 8219	1 🔀 M 2 🗆 F			ONTHS DAYS		4464	(Month, Day, Year)		Country)
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3 shc	<u>ac</u>	K.			,	b. CITY, TOWN	OR LOCATION (OF DEAT	Н	9c. COUNTY	
0,	CTOR	1403 Franklin Ave	3			Essex				Balt	imore
	S	10a. STATE 10b. COUNTY			100 CITY I	TOWN OR LOCAT	104				
20	DIRE						ION				10d. INSIDE CITY LIMITS?
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ž	Z.	106. STREET AND NUMBER				10	. ZIP CODE			10g. CITIZEN	N OF WHAT COUNTRY?
anst	9	1403 Franklin Ave	9				21221			U	J.S.A.
-0020 ling physician. the burlal-transit permit. Pages	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 X YE	R IN U.S. ARME	D	13. WAS DEC	ENDENT OF H	IISPANIC	ORIGIN? (Specify Yes		. RACE — American Indian, Black, White, etc.
00 a	BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR	DATES			25 NO S		Puerto Rican, etc.)		SpeedlyWhite
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121 use	<u> </u>	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECE	DENT'S US kind of worl	WAL OCCUPATION k done during monetired.)	ON st of working		16b. KINO OF BUS	INESS/INDUS	TRY
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AND he hospit detached	A P	0		Snee	c met	al mec	nanıc		Areo-spa	ace	
AND 21215-0020 the hospital or attending physician detached for use as the burial-tranonce.	COMPLETED	17. FATHER'S NAME (First, Middle, Last)							(First, Middle, Maiden S	Sumame)	
# & # Z	BE	Baleslaus Rakov	/ski				Anto	inet	tte Gardy	yan	
MARYLAND 21215-0020 s retained by the hospital or attending physic 5 should be detached for use as the burial notified at once.		19a. INFORMANT'S NAME (Type/Print)		19b. N	AILING AD	DRESS (Street a	nd Number or F	Rural Rou	te Number, City or Town	, State, Zip Co	ide)
No Peret	2	Elizabeth M. Rako	wski	140	03 Fr	anklin	Ave.	Esse	ex, Maryla	and 21	221
RE, page		20a. METHOD OF DISPOSITION	2	Ob. PLACE AND	DATEOF	DISPOSITION (No				-	y or Town, State
TOR e 6 may ector, p		1 Suriet 2 Cremetion 3 Remo	val from Stata	emetery, crema	tory or other	place)	2	/13			, Maryland
		21. SIGNAFURE OF FUNERAL SERVICE LIC		1017 61	2000					THOLE	Maryland
ALTIN death. Pag b funeral di examiner	1	• ()	0.	,					neral Home		
BA the fight of th	-	1	2	1		1407	Easter	n Av	re Baltimo	ore, M	aryland 21221
		23. PART . Enter the diseases, or c ahock, or heart failure. I	omblications that caus	ed the death	n. Do not	enter the mo	de of dying,	auch a	a cardiac or reapir	atory arrest	
8 4 8 6		IMMEDIATE CAUSE (Final	only one cease on		1						interval Between Onset and Death
the the		disease or condition resulting in death)	. (/	10 kel	who	· Can	cal				
WT60. ured withh		resoning in death)	DUE TO (OR AS								
C 68760 executed with and comple or burial, cre	z										
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CORDS, res that the deal igned by the att eatth and Menta and Injury,	A	PART II. Other algnificent conditions	contributing to death	but not resi	ulting in t	the underlying	cause give	n In Pa	rt I. 24a, WAS AN		24b. WERE AUTOPSY FINDINGS
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ON DING After death	B	2 Accident Investigation	20. 51 405 05 11 11			M 1 1		_			
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DIVISION OR ATTENDING P DIRECTOR: After hours after death	E 1										
	리	29a. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my kno	wiedge, death	occurred a	t the time, data	and place, and	d due to	the cause(s) and menr	ner as stated.	
HERITAL HILL TZ INNERAL WITHIN 72 IANT: If	COMPLET										ause(s) and manner as stated,
E ST E	- 10	29b. SIGNATURE, AND TITLE OF CERTIFIER					29c. LICENSE	ENIMBE	ь Т	tor DATE OF	owendarium du mus
TO THE HOURT TO, THE FUNER De filed within T	B		MD.				1)	CLI	67	294. DATE SH	GHED/Month, Gry, Year)
₽-₽2 ₹	2	30. NAME AND AODRESS OF PERSON WHO	COMPLETED CAUSE OF	DEATH (ITEM **	7) (Time 19-1	inti	ווע	07	0/	0	7/19/93
1 1		MYO THAI	VT 9			MKLIN	1 50	7.	no n.	170	4071227
10		31. DATE FILED (Month, Day, Year)	1 1 DECETEING		· V//		-((10/10/	210,1	10010
		FFR 1 & 1005 4	SE REGISTRATISMO	delle							
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permit. I Page 6 may be retained by the hospital or attending physician. after death. hours a

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

page 5 should be detached for use as the burial-transit director, and completely filled in by the funeral bundal, cremation, or removal. or removal

attending physician intal Hygiene prior to

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OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate bours after death with the State

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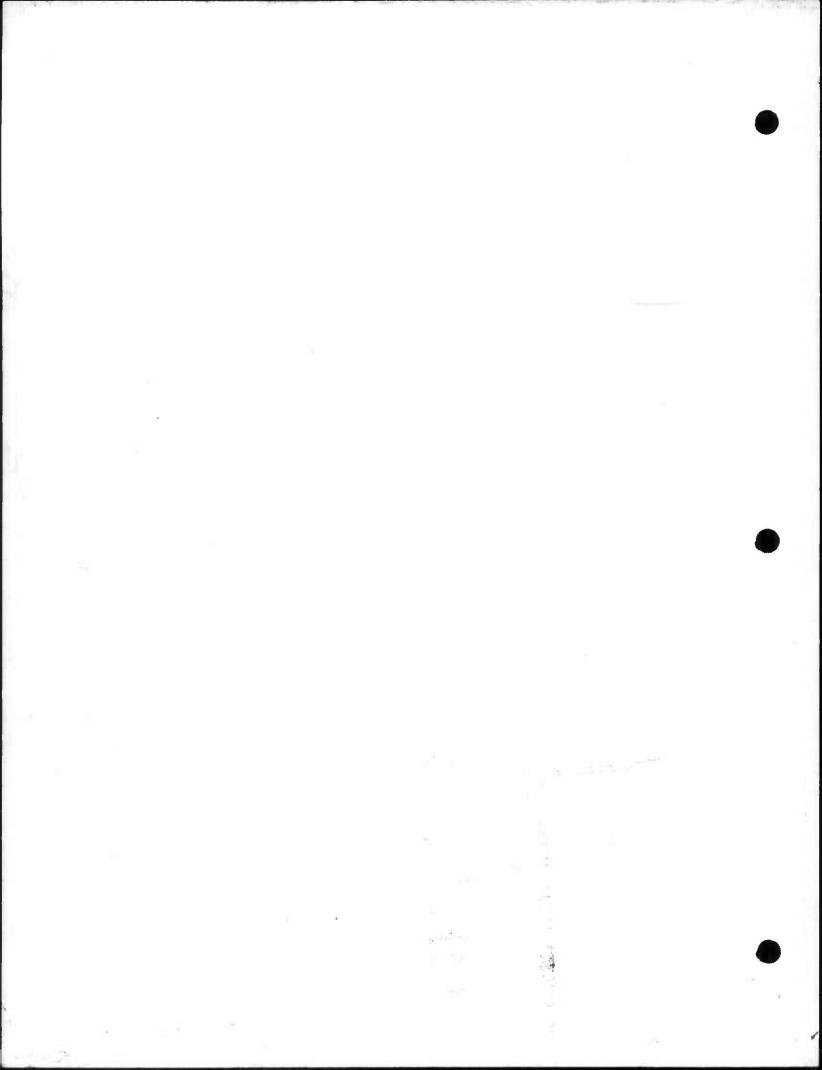
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FilmG, 723, item #11, 5/17/95, cyw, per. wife blh STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR Jr. Lawrence Ruff Feb 1995 0947 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday 7. DATE OF BIRTH (Month, Day, Year) May 5,1932 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 218-26-1697 DAYS 62 1 X M 2 - F YRS. Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1346 Towson Street None Baltimore 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland None Balto.City, Md. TYPES 2 | NO FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1346 Towson St. 21230 United States 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE - American Indian, Black, White, etc. FORCES? TYPES 2 NO 1 Never Married 2 Merried If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES X XNO Specify: BY Midawed 4 Divorced White Korea COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8th.Grade None Asbestos Worker Loca1 # 11 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Lawrence J.Ruff, Sr. Mary C. Conway BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr.Steven L.Ruff, Sr. 503 E.Barney St.Balto.Md.21230 99 20s. METHOD OF DISPOSITION
1 ∰ Burlet 2 □ Gremation 3 □ Removat from State
4 □ Donation /5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Cedar Hill Cemt. 2/16/95 A.A.Co.Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND AOORESS OF FACILITY Balto.Md.21230 McCully Funeral Home, 130 E. Fort Ave medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory street, Approximate shock, or heart failure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease event, Diabetes Mellitus traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS amy AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 X NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1X YES 2 NO ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED is marked, 1 🔯 Natural 5 Pending 1 YES 2 NO В 2 Accident Investigation 3 Sutctde 28e. PLACE OF thJURY — At home, term, street, tactory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end menner as stated. 2 X MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occured at the time, data and place, and dus to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 222 2 O.C.M.E Feb 13 1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Fowler 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, Day, Year) R. REGISTRAR POSIGNATUR 1995



DHMH-16 Rev 1/89



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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Pridl)

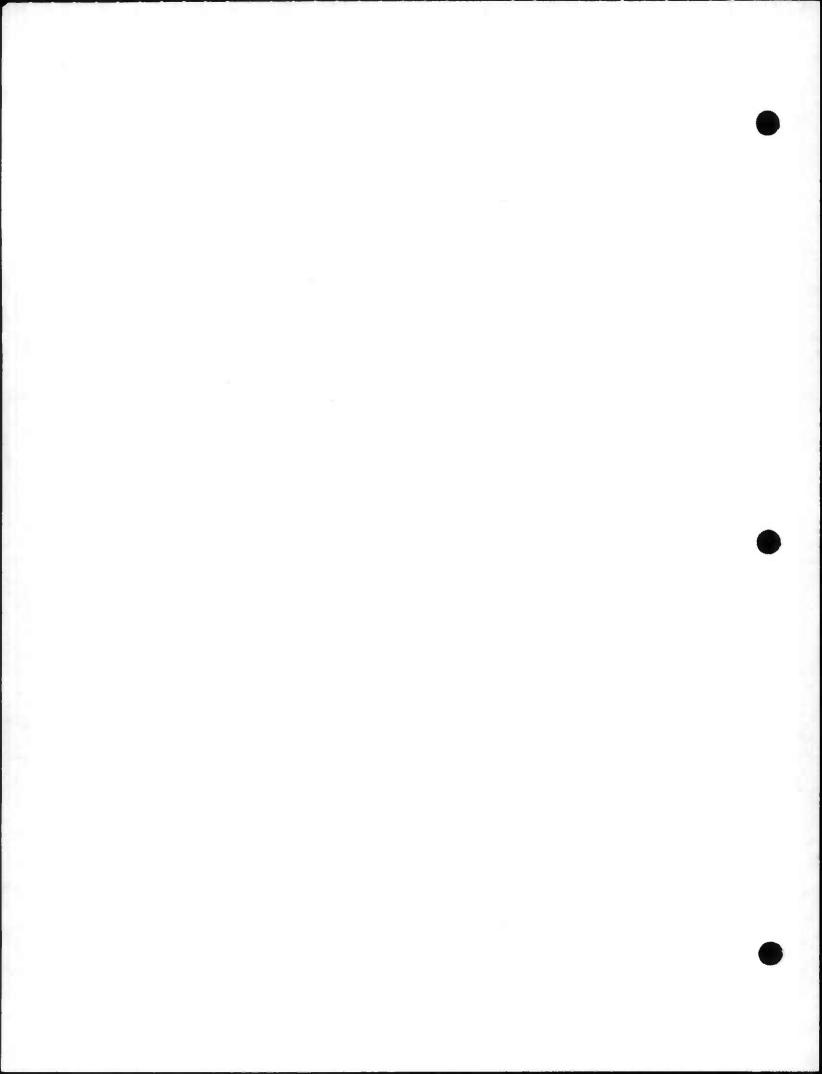
Sukh Dev Auila M.D. 5211 Harford Rd.

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marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

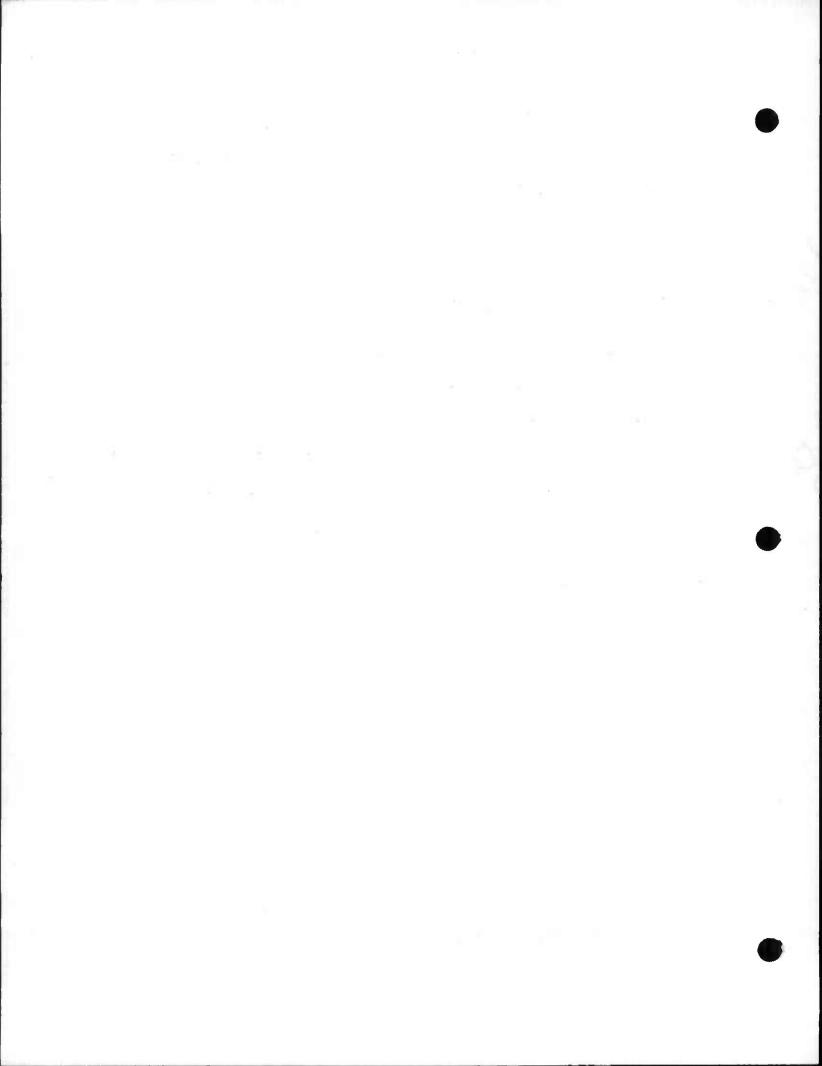
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA			HEALTH AND	MENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	Herman F. Robe	erts				February		M
	4. SOCIAL SECURITY NUMBER		yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	0. Bi	RTHPLACE (State or Foreign
	216-10-6515 So. FACILITY NAME (If not institution, give str	1 × M 2 □ F 70		MONTHS DAYS	OR LOCATION OF DE	December	4.19 5	New Jersey
BY FUNERAL DIRECTOR	5005 Sinple Ave				re . City		9c. COUNTY O	OF DEATH
<u> </u>	10a. STATE 10b. COUNTY		10c. CITY	TOWN OR LOC	ATION			10d, INSIDE CITY
품	Maryland		Do 1	timono	. City			LIMITS?
1	10e. STREET AND NUMBER		L_Dd1	LIMore	OI, ZIP CODE		10a CITIZEN C	OF WHAT COUNTRY?
18	5005 Sipple Ave.				21214			AND THE RESERVE
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딥	1 Never Married 2 Merried	FORCES? 1 X YES	2 NO	If yes, s	pecify Cuben, Mexice	n, Puerto Rican, atc.)	or No 14. H	ACE — American Indian, Black, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	TES	1 🗆 YE	S 2 NO Specify	<i>r</i> :	S	pecify:
Ω.	15. DECEDENT'S EDUCA	ATION	16e. DECEDENT'S 1	ISUAL OCCUPAT	ION	16b, KIND OF BUS	INESS (INDICETE	White
E	(Specify only highest grade of Elementary/Secondary (0-12)	completed)	(Give kind of wi	ork done during n	nost of working	100. KIND OF BUS	MESSAMDUSTA	,
P.	Elementary/Secondary (0-12)	College (1-4 or 5+)	Milk Ma	n		Cloverl	and Dai	rv
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		TITTIC TIO	.11	10 MOTHED'S NA	ME (First, Middle, Meiden		1 9
Ö	John Francis Ro	harts			The state of the s		nown	
8	19e. INFORMANT'S NAME (Type/Print)	Del 63	10h MAH INO	DDDESS (Com.)		Route Number, City or Town		
5	Mrs. Jaen D. McG	'nath					n, Stere, Zip Gode,)
	204, METHOD OF DISPOSITION	-			naus Rd.			
	1 Burlet 2 Cremation 3 Remove	val from State ceme	PLACE AND DATE Of tery, crematory or oth	er place)		1	CATION — City o	
	4 Donation 6 Other (Specify)) N	loreland	Mem. P	<. 2/16/9	5 Ba	<u>lto. Md</u>	
	The state of the s	01 11		I.eon	and address of fa	ck Funeral	Home.	Inc.
	Youdd C Ash	shel Se		5305	Harford	Rd. Balto.	Md 21	214
	23. PART I. Enter the diseases, or co	Inplications that caused	the deeth. Do no	ot enter tha m	ode of dying, suc	as cardiac or respi	ratory arrest,	Approximata
	shock, or heart fellure. £ IMMEDIATE CAUSE (Final	lst only one cause on aa	ch line.					Interval Between Onset and Death
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	resulting in death)	u Cocci a	0 01					
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RTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	-		713		
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프	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	:				
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용	Essential	upperser	version	1 Emp	hysem	A 1 TYES 2		COMPLETION OF CAUSE OF DEATH?
MEDICAL	cardiae a	rrhythin	us, va	ricos	e very			1 TES 2 NO
ż	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF	DEATH YES	PNO [UNCERTAIN	10		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		6. PLACE OF DEATH	(Check only one)			
Sic		PLOSPITAL: 1 Inpatient 2 ER/Outpa		OTHER:	me 5 🗌 Rasidence	8 Other (Specify)		
≥		27. MANNER OF DEATH 288. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED						
-			INJU		ORK? YES 2 NO			
	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)						
B	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26e. PLACE OF INJURY	At home, farm, at		ce	281. LOCATION (Street a	nd Number or Rui	ral Route Number,
ED BY	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation		At home, farm, at		ce	281. LOCATION (Street a City or Town, State)	nd Number or Rui	ral Route Number,
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		1 - STATE REGISTRAR	STATE OF MAR			ICATE				IENTAL HYGIE REG. N			
		1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH MONTH	DAY	YEAR 3.	TIME OF DEATH
		JAMES 4. SOCIAL SECURITY NUMBER	lbert 8.4	105 //		RODI	_		\rightarrow	FEB	12	95 1	2:29 PM
		212-30-1916	1 🕅 M 2 🗆 F	AGE (In yrs. last	YRS.	IF UNDER	DAYS	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	022	Country)	CE (State or Foreign
3 should		9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY	, TOWN O	R LOCATI	ON OF DEA	03/08/1		PEIIII	sylvania "
ci .	CTOR	HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE CITY											
Jes 1,	E C	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Y		10c. CIT	Y, TOWN C	OR LOCAT	ION				100	I. INSIDE CITY
¥.	DIRE	Maryland	Baltimore	e				D	undal	k		1{	LIMITS?
ft perm	FUNERAL	10e. STREET AND NUMBER					101.	ZIP COD			1.5	EN OF WHAT	
cian. I-trans	SNE	12 Winona Avenue	12. WAS DECEDENT EV	/ER IN U.S. ARI	AED	13.	WAS DEC	ENDENT C		21222 C ORIGIN? (Specify		ted S	tates American Indian,
YLAND 21215-0020 by the hospital or attending physician. be detached for use as the burlat-transit permit. Pages 1, at once.	BY FI	1 Never Married 2 Narried 3 Widowed 4 Divorced	FORCES? 1 T	YES 2 N			If yes, spe	ecify Cuba	n, Mexican, Specify:	Puerto Rican, atc.)	N 0 NO -	Black, WI Specify:	White
	ED	15. DECEDENT'S EDU (Specify only highest grade	ICATION COMPRESSION	16a. DEC	EDENT'S	USUAL Of	CCUPATIO	N		16b. KIND OF I	BUSINESS/INDI	USTRY	
21 or differ of	LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	iiie.	Do NOT u	se retired.)			ry	Comme	rcial	Trans	portation
ANE hosp detache	COMPL	8 Years 17. FATHER'S NAME (First, Middle, Last)			Tru	ck Di	rive		IFR'S NAM	E (First, Middle, Maid	an Sumama)		
YL B	1	James Albert Ro	denizer, S	r.						Grace Tr		:	
MARYLAND 212: retained by the hospital or att 5 should be detached for use notified at once.	0	19a. INFORMANT'S NAME (Type/Print)								oute Number, City or 1		Code)	
Page 5		Mrs. Katherine							Dur	ndalk, MI			1877a
BALTIMORE, Is after death. Page 6 may be not by the funeral director, page removal.		*Buriel 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	novel from State	206. PLACE A cemetery, cren Du Lane	natory or o	ther place)	y Me	m. G	dns.2	DATE 20c.	Location — d Timoni	Lum, M	State D
death. Pag tuneral dir i.		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			22.	NAME AN	D ADDRES	SS OF FAC				
BAI the fur oval.		2 Dans	Coud		-	7:	922	Wise	Ave.	Dundal	k, MD	2122	
A hours after filled in by th on, or remova		23. PART I. Enter the diseases, or shock, or heart failure.	List only one ceuse of	on eech iina.	ith. Do r	not anter	the mod	de of dyl	ng, such	as cardiac or res	piratory arre	est,	Approximata interval Between
tely fill nation.		IMMEDIATE CAUSE (Final disease or condition resulting in death)	Hhero	sder	oho		Cur	dio	Vasi	cular	dise	are	Onset and Daath
			DUE TO (OR	AS A CONSEO	UENCE O	F):							
× 8 2 E	ERTIFICATION	Sequentially list conditions, if any, leading to immediate	b DUE TO (OR	AS A CONSEO	UENCE O	F):							
certificate be ending physician a Hyglene prior to or other traum	ICA	cause. Enter UNDERLYING CAUSE (Disease or injury	C	45 4 00M050	151105 0								
, P.O. B eath certificate attending physimal Hyglene pry, or other t	RTIF	that initiated events resulting in deeth) LAST	40) 01 300	AS A CONSEQ	UENCE O	-):							
	CE	PART II. Other significant condition	a contributing to dea	th but not m	oultino.	in the un	dodulos		duce le D				
2 2 4 4 2	ICAL		va dominating to date	itii but iiot je	Joiling	iii tiia uii	derlying	Ceuse (jiven in P	PERF	ORMED?	AVA	RE AUTOPSY FINDINGS ILABLE PRIOR TO IPLETION OF CAUSE
Sa ires	MED									_ 1 □ YES	2 5200		DEATH? YES 2 NO
		DID TOBACCO USE CONT	RIBUTE TO CAUSI					UNC	ERTAIN	(EI)			
一年 報報 5	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X XES 2 \(\) NO	HOSPITAL:	26. PLACE	T	OTHER	R:						
T 3 9 4 .	PHYS	27. MANNER OF DEATH	1 Inpetient 2 TVER/	URY	28b. TIM	E OF	28c. INJU	JRY AT		Other (Specify) 28d. DESCRIBE HOY	Y INJURY OCC	URED	
ON OP DING PHYS After this death with	ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye	bar)	INJ	URY M	1 🗌 Y	ES 2	NO [
ISIC TTENDI TTOR: A after d	<u>a</u>	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF IN. building, etc.	JURY — At hon (Specify)	ne, term, s	street, tect	ory, office			261. LOCATION (Stree City or Town, Ste	et and Number (or Rural Route	Number,
DIVISION OR ATTENION DIRECTOR: hours after Item 28 is	LET	29a. CERTIFIER (Check only 1 CERTIFYING PHYS	ICIAN: To the best of my is	knowledge, dea	th occurr	d at the ti	me, date	end place	and due to	the causels) and n	anner en elete	4	
TO THE HOSPITAL (TO THE FUNERAL COMPANION TO THE MATHER TO THE MATHER TO THE MATHER TO THE THE THE THE THE THE THE THE THE THE	COMPL		R: On the basis of example										f manner as stated.
TO THE HOSPI TO THE FUNER be filed within	BE C	29b. SIGNATURE AND TITLE OF CENTIFIE	1011	01				29c. LICE	NSE NUMB	ER	29d. DATE	SIGNED (Mor	nth, Day, Year)
D D D	10	30. NAME AND ADDRESS OF PERSON WH	U COMPLETED CALLET CO	E DEATH ATTE	ATD 47	Delete		0.0	C.M.	Ε.	▶ F	EB 1	3,1995
(X)		David R F	WOLLETED CAUSE OF				Str	eet	. Ra	ltimore	Mar	wlan.	d 21201
1		31. DATE FILED (MOOTE Day West)	32. BEGISTRAR'S			J.1.1.1		JUL	, ,,,,,,,	T CAHOL C	, Hul	J Tuil	4 21201

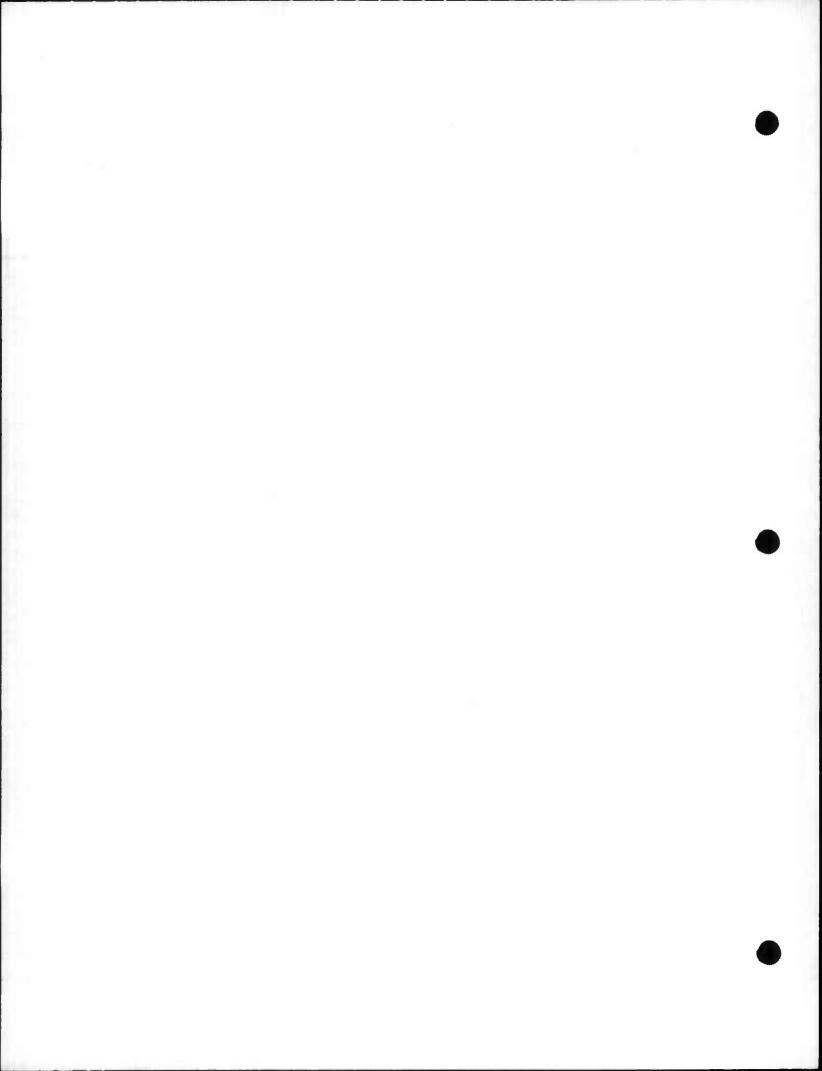


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AL OR ATTENDING L DIRECTOR: After Z hours after dea	SET IN THE INDING PHYSICIAN: The law requires that the death certificate be executed within TS hours after death. Page 6 may be retained by the hospital or attending physician.	URECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should	Prours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	Mr. Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
AL OR ATTENDI L. DIRECTOR: A Z hours after di I tem 28 Is	ING PHYSICIAN: T.	fter this certificate	eath with the State	marked, or Itel
	AL OR ATTENDI	IL DIRECTOR: A	2 hours after d	I Item 28 Is

1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, I	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIE CERTIFICATE OF DEATH 2. DATE OF GEATH 2. DATE OF GEATH	
FOR	STATE OF MARYLAND / DEPARTMENT OF MEALTH AND MENTAL MYOLE	N.E.

	7180101111111					ICALL	- OF	DEAL		HEG. NO.			
	1. DECEDENT'S NAME (First, REBECC)				2. DATE OF DEATH MONTH DAY YEAR 9.05			TIME OF DEATH					
	REBECCA ROSENTHAL 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. les				st birthday)	IF UNDER 1 YEAR					ACE (State or Foreign		
~	218-32-8186 1□ M 2 ⋈ F 83				YRS.	MONTHS	ONTHS DAYS HOURS MIN. (Month, Day, Year) Country)			RYLAND			
	9s. FACILITY NAME (If not institution, give street end number)					9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH							
O.	SINAI HOSPITAL					BALTIMORE							
[[RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY 18e (Y, TOWN OR LOCATION							
FUNERAL DIRECTOR	MARYLAND BALTIMORE					BALTIMORE					Dd. INSIDE CITY LIMITS? YES 2 NO		
	10s. STREET AND NUMBER						101. ZIP CODE				10g. CITI	ZEN OF WN	AT COUNTRY?
	2826 MARNAT ROAD, APT.D					21209				L	U.S	.A.	
	1 Never Married 2 Married FORCES? 1 YES 2 No				NO NO	If yes, s			DECENOENT OF HISPANIC ORIGIN? (Specify) specify Cuban, Mexican, Puerto Rican, etc.)			Black, White, atc.	
BY	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES					1 TYES 2 X NO Specify:					Specify:	WHITE	
COMPLETED	15. DEC	EDENT'S EOUC	ATION	18e, O	ECEDENT'S	USUAL OCCUPATION 16b, KIND OF				16b. KIND OF BUS	BUSINESS/INDUSTRY		
	Elementary/Secondary (0		College (1-4 or 5) //h	e. Do NOT us								
MP	10th			H	OUSEW	IFE	IFE AT I				HOME		
	17. FATHER'S NAME (First, MI JACOB H	iddle, Last) UBBERM	7. 7.7					16. MOTHER'S NAME (First, Middle, Maiden Surname)					
BE	19a. INFORMANT'S NAME (7)		HILV						JENN	BA	AITCH		
2	MR. LOUIS		ΕΝΨΗΔΙ.							D, BALTO., M			
	20e. METHOD OF DISPOSITI	ON		20b. PLACE					AFI.			City or Town	
	1 Buriel 2 Cremetio	n 3 (Pamo	yel from State	AGUDAS	S ACH	her place!	NSHE	SFA	RD C				
	21. SIGNATURE OF FUNETIAL		457										
	1 //20	L.	1				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD. 21215					01015	
17	23. PART i. Enter the di	seasos, or c	amplications the	t ceused the d	aath. Do r	not antar	the mo	de of dvi	TERS	TOWN RD., B	ALTO	. , MD.	
	snock, or ne	ert Isliute. L	lst only one cau	se on eech lin	е.		tria mo	aa or ayr	119, 40011	res cardiac or respir	atory arr	est,	Approximata interval Between
	immediate Cause (Final disease or condition resulting in death) e. Hypotensio										Onset and Death		
	resulting in death)		gu€ TO	(OR AS A CONSE	OUENCE OF	F):	3						101113
Z	Communication 22-4 and adda.		Cara	iogen	ic .	Sna	CK						13hrs
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events b. CONDICOCNIC Shock DUE TO (OR AS A CONSEQUENCE OF): C. Encephologothy DUE TO (OR AS A CONSEQUENCE OF):									In			
5	CAUSE (Disease or inju	ng a	MON	IC (-n(E	phe	re	pat	14				10hrs
Ē	thet initiated events resulting in death) LAS		002 10	(On AS A COMSE	OUENCE OF	7.			0				
CEI		4											
¥	PART ii. Other significan	nt conditions							jiven in F	Part i. 24e. WAS AN /			ERE AUTOPSY FINDINGS AILABLE PRIOR TO
EDICAL	_Small	bou	xe/ Ox	struct	-10h	St	are	IS PO	ast.	1 YES 2		CC	OMPLETION OF CAUSE
Σ	explora		Lopar	Otomo	1					_		1	□ YES 2 NO
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN												
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:			OTHER	-						
¥ ₹	1 YES 2 NO		1 Nonpetient 2		1				-	Other (Specify)			
BY PI						HE OF 286. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/							
	3 Suicide 8 Could not be 4 Homicide detarmined					treet, fact	reet, factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete)				e Number,		
DE-COMPLETED	Mo CERTIFIE												
를	(Check only									to the cause(a) and man			
B			. On the beste of e.	camination and/or	investigatio	n, in my o	pinion, de	eath occur	ed at the t	lme, data end piece, end	due to the	e ceuse(a) ar	nd manner as stated.
	296. SIGNATURE AND TITLE OF CERTIFIER JEDRYSIAK, A, HD. 29c. LICENSE NUMBER AJ414 7357 O2/11/95												
0	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS				2-	27 .	0.1	-14.15			, .0
	JEDRYS	IHK,	4 MI)	SIL	PAI	HOS	471	74, x	SAL	MYORE			
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE												
	FEB 1 6 19	95 Ju	ly d'huoles	x Rardall									



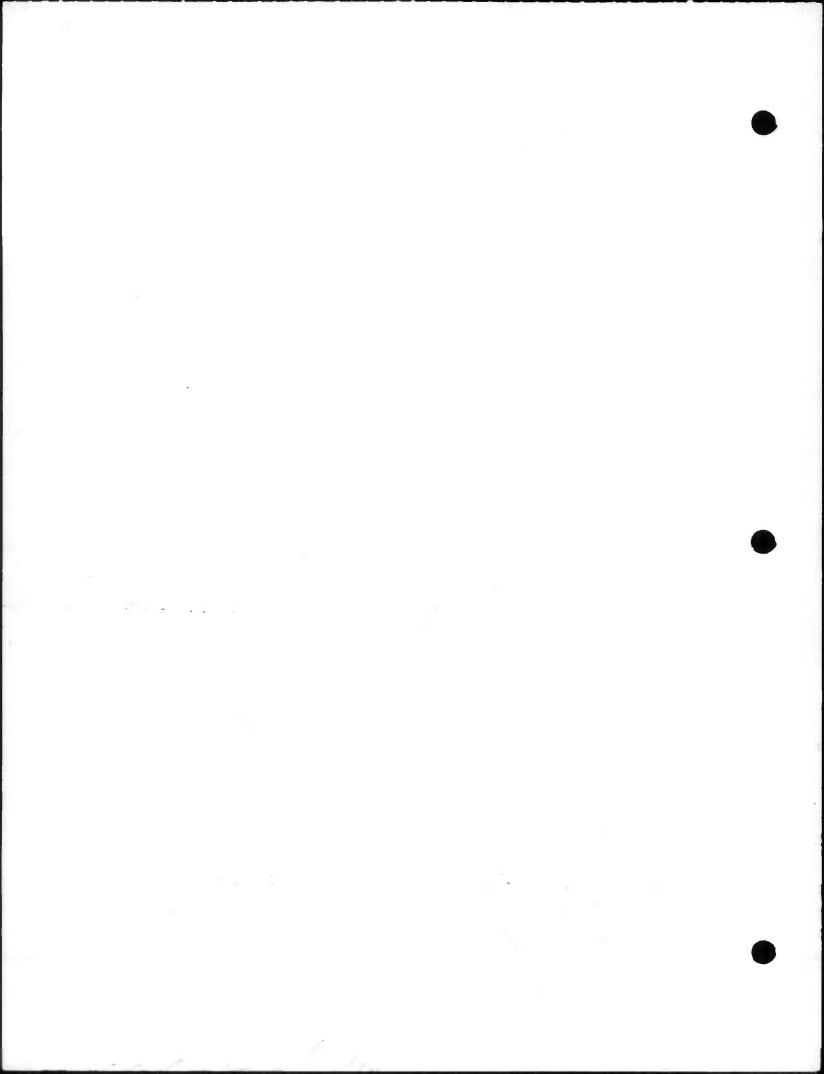
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DIVISION OF VITAL RECOI

TO THE SPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with property of the feath. Page 6 may be retained by the hospital or attending physician.

FORTHEN SIZE DISCORDS: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use 3 shows any injury, or other transmitter event, the medical examiner must be notified at once. AND 21215-0020

	1 - FOR STATE REGISTRAR	TE OF MARYLAND / DEPARTM CERTIFIC	MENT OF HEALTH AND	MENTAL HYGIENE REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH 3. TIME OF DEATH							
	SYLVIA SINGLETON			FEBRUARY 10,1	995 1:10 P. M						
	4. SOCIAL SECURITY NUMBER 5. SEX 212-26-6931A	an riske (iii yiai raat antriday)	UNDER 1 YEAR IF UNDER 24 HRS. NTHS DAYS HOURS MIN.		8. BIRTHPLACE (State or Foreign Country) S.C.						
_	9a. FACILITY NAME (If not institution, give street and	number) 9t	CITY, TOWN OR LOCATION OF DI	EATH 9c. COUN	TY OF DEATH						
DIRECTOR	STELLA MARIS	HOSPICE	BALTO								
55	10a. STATE 10b. COUNTY	10c. CITY, T	OWN OR LOCATION		10d. INSIDE CITY						
	MD	BAL	IO		LIMITS?						
FUNERAL	100. STREET AND NUMBER 1102 N. MONROE ST		10f. ZIP CODE 21217	10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
N.		S OECEDENT EVER IN U.S. ARMED		IIC ORIGIN? (Specify Yas or No							
	1 Never Married 2 Married FO	PRCES? 1 YES 2 WNO YES, GIVE WAR OR DATES	If yea, specify Cuban, Maxica	n, Puarto Rican, etc.)) Black, White, etc.						
В В	3. Widowed 4 Divorced		1		Specify:BLACK						
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade complete		done during most of working	16b. KIND OF BUSINESS/INDU	JSTRY						
1 3 5	Elementary/Secondary (0-12) Colleg	ge (1-4 or 5+) life. Do NOT use re									
OMI	17, FATHER'S NAME (First, Middle, Last)			ME (First, Middle, Meiden Surname)							
ш	BLANEY SINGLETON		ELLEN								
TO B	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING AD	DRESS (Street and Number or Rural I	Route Number, City or Town, State, Zip (Code)						
F	JANET JACKSON	2524	PAK HEIGHTS	TERRACE BALTO,	MD 21215						
	20e. METHOD OF DISPOSITION (☼☐ Burial 2 ☐ Cremation 3 ☐ Ramoval Iron	m State 20b. PLACE AND DATE OF D		OATE 20c. LOCATION — C							
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	DOBBINS HE	CIGHTS CEMETERY 22. NAME AND ADDRESS OF FA		N.C.						
	Gerome a	minn To			SH AVE						
	23. PART . Inter the diseases, or complic	etions that caused the death. Do not		- WADAC							
	shock, or heart fellure. List onl	ly one ceuse on each line.	12. 12. 12.0		Interval Between Onset and Death						
	disease or condition resulting in death)	ung Canses	- small cl	(6 cabo						
	DUE TO OR AS A CONSEQUENCE OF:										
N N	Sequentially list conditions, b. July Melastates bucks.										
ATI	if any, leading to immediate couse. Enter UNDERLYING	DUE TO (OR AS A CONSEQUENCE OF):									
	CAUSE (Disease or Injury thet initiated events	DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	resulting in death) LAST										
AL C	PART II. Other aignificent conditions contri	PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
EDICA				PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE						
ME					OF OEATH?						
ż	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
PHYSICIAN:	EXAMINER? HOSE										
1×S			☐ Nursing Home 5 ☐ Rasidence	8 X Other (Specify) HOSPI							
	1 Natural 5 Pending	(Month, Day, Year) INJURY	F 28c, INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCU	UREO						
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	Be. PLACE OF INJURY — At home, farm, stree		281. LOCATION (Street and Number or Rural Route Number,							
ETED	4 Homicide detarmined	building, etc. (Specify)		City or Town, State)							
P.E.	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To	the beat of my knowledge, death occurred at	t the time, data and place, and dua	lo the cause(s) and manner as states	d.						
COMPL		e beele of axemination end/or investigation, in									
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	2. 0:	29c. LICENSE NUN	IBER 29d. DATE	SIGNED (Month, Day, Year)						
0	Grendall CI	-audencinc	10250	043 ► FE	B. 10, 1995						
	30. NAME AND ACCRESS OF PERSON WHO COMPL		,	VD 01001							
	DR. KENDALL FAULKNER 31. DATE FILEO (Month, Day, Year) 32.		LEY KD., TOWSO	N, MD 21204							
	31. DATE FILEO (Month, Day, Year) FEB 1 6 1995 Silva	disclor hardell									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

	isit permit, Pages 1, 2, 3 should	
by the hospital or attending physician	be detached for use as the burial-tra	at once.
after death. Page 6 may be retained	y the funeral director, page 5 should	cal examiner must be notified
ficate be executed within 24 hours	physician and completely filled in the	ury, or other traumatic event, the medi
e law requires that the death certi	has been signed by the attending	item 23 shows any injury, or oth
OR ATTENDING PHYSICIAN: The	DIRECTOR: After this certificate	IR IANT: Il tem 28 is marked, or item
E HOSPITAL	FUNERAL TOWNER	BRANT: II

											9	5 1	04914	
	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR ERTIF	TMENT	OF H	EALTH DEAT	AND N	/ENT	AL HYGIENI REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) WILLIAM	JOHN		SCH	EFFE				2. DAT	Feb 15	1996	5 YEAR	3. TIME OF DEATH 12:15 an	n M
	4. SOCIAL SECURITY NUMBER 212-26-7210	5. SEX 1 ☑ M 2 ☐ F	6. AGE (In yrs. lest	t birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS. MIN.	(Mor	E OF BIRTH oth, Day, Year)		Counti	* *	eign
	9a. FACILITY NAME (if not institution, give st	^	65	1110.	ah OITY	70401	R LOCATIO			-16-192			ryland	
FUNERAL DIRECTOR	Saint Joseph Hospi				90. CITY		BON,				9c. COL	Baltin		
EC	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN C	OR LOCAT	ION						10d. INSIDE CITY	
DIR	Maryland						City						LIMITS?	
7	10e. STREET AND NUMBER				21611		ZIP CODE				10a. CIT	TIZEN OF Y	WHAT COUNTRY?	
ER/	3211 Westfield Ave	۵.				(18)	2121	/						
N	11. MARITAL STATUS	12. WAS DECEDEN	IT EVER IN U.S. ARI	MED	13.	WAS DEC			IC ORIG	IN? (Specify Yea		U.S.F	E — American Indian	
ВУ F	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE Y		10		If yes, sp	cify Cubai	n, Mexican Specify:	, Puarto	Rican, etc.)		Speci	k, White, etc.	'1
			orea										White	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(Gir	CEDENT'S ve kind of Do NOT u	Work done	during mo	N st of workin	g	16	b. KIND OF BUS	INESS/IN	DUSTRY		
P	Elementary/Secondary (0-12)	College (1-4 or 5	+)	Sa					-1	Machi	D 0 101			
MO	17. FATHER'S NAME (First, Middle, Last)	. , ,		Ju			18 MOTH	IED'S NAM	AE /Elect	Machi Middle, Meiden S		Y		
Ö	William B		Scheffe	2]			1.71	lna	ME (FRSI,	A.	urnama)	Scha	n70	
8E	19a. INFORMANT'S NAME (Type/Print)				ADDRESS	(Street a			oute Nue	nber, City or Town	State 7		inze	
2	Mrs. Holly S. Samp	ery					1 Rd			imore,			27	
	20a. METHOD OF DISPOSITION		20b. PLACE A									· City or To		_
	1 Burial 2 XCremation 3 Ramo	oval from State	cemetery, crer	natory or o	ther piecel		ce	2/1	1			. Md		
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE Paul	L. Hartson	ck.Jr	22.	NAME AN	D ADDRES	SS OF FAC	HLITY	Baltim			21214	
	Doulf blat	- 2 2		, ,										
	23. PART I. Enter the diseases, or co	omplications the	t caused the de-	eth Do	L L	eona	rd J	. Ru	ck,	Inc. 5	305	Harf		
	snock, or heart failure. L	lst only one cau	ise on each line.		rot anter	the mo	ue or ayı	ng, sucn	aa ca	rulac or reapir	story ar	rest,	Approximat Interval Bet	ween
	IMMEDIATE CAUSE (Final disease or condition	CCCCT	ETIO VAL				-						Onset and I	
	reaulting in death)		(OR AS A CONSEO			JAHL	11115						3 WEEK	-
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S	cause. Enter UNDERLYING CAUSE (Disease or injury												ļ	
E	that initiated events	DUE TO	(OR AS A CONSEO	UENCE O	F):						-			
	reaulting in death) LAST													
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COMPLETED	(Check only one) 2 MEDICAL EXAMINER												and manner se stat	ad .
ö	29b. SIGNATURE AND TITLE OF CERTIFIER				, 0	1								₩ 0.
H	nutraided A	1. 1. 1		ha 4	9			195			29d. DAT	E SIGNED	(Month, Day, Year)	
9	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	SE OF DEATH (ITEM	27) /7000	Print)		~	113	0	0		V	113/93	
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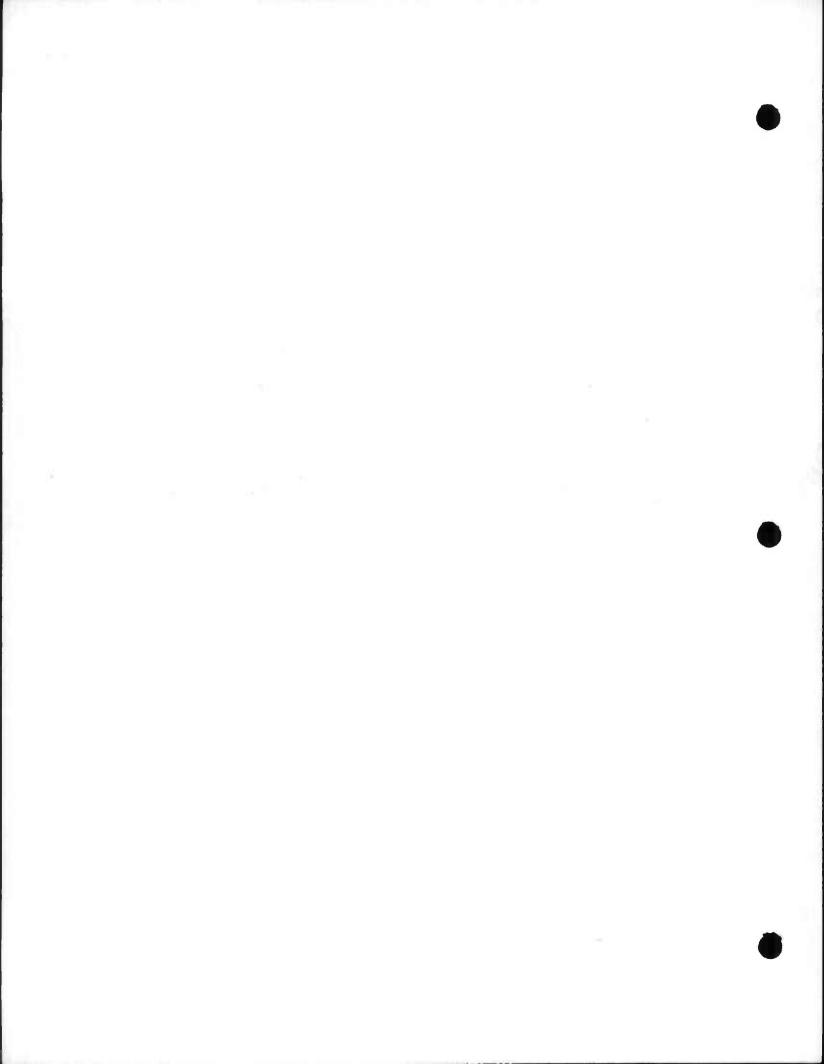
HATIVIDAD DELEON MD 21204

11: date fileto (North, Day 1997)

FEB 1 6 1995

DALIMONE, MAN LAND 21213-0020	YSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should	removal.	edical examiner must be notified at once.	
	THE HOW TIME OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hour	THE TANTIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in	Inc. (with 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	other it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - STATE REGISTRAR	STATE OF MARY		IMENT OF H		MENTAL HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN		3. TIME OF DEATH	
	Koith Edwa	ixd Sov	00110			Feb. 12		1 A	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN	S. BIR	THPLACE (State or Foreign	
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OC.	9e. FACILITY NAME (If not institution, give st				R LOCATION OF DI	EATN	9c. COUNTY OF		
DIRECTOR	Fallston General	Hospital		Fallst	on		Harf	ora	
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B√	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1 🗆 YES	2 XNO Specif	y:	Sp	white	
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	Elementary/Secondary (0-12)	College (1-4 or 5+)	Iffe. Do NOT us	e retired.)		tor Amh	21+		
₩.	12 Years 17. FATHER'S NAME (First, Middle, Last)		Aspnalt	Reine		tor Asph			
8	Garnold E. Spra	m10				ME (First, Middle, Maiden	Surname)		
B	19a. INFORMANT'S NAME (Type/Print)	que	105 MAILING	ADDRESS (Street or	Rita F.	Route Number, City or Tow	- Charles Tim Control		
2	Mrs. Lorene Spra	aue				Way Edgew		21040	
	20a. METHOD OF DISPOSITION **XBurial 2	20	b. PLACE AND DATE O	E DISPOSITION (Na	me of	DATE 200 LO	CATION - City or	Town State	
	4 Donation 5 Other (Specify)	ovisi from Stata Ce	ometery, crematory or other Lawn	Cemeter	y 2/16/	95 Baltimore, MD			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22. NAME AN	D ADDRESS OF FA	CILITY			
	52					neral Home Dundalk			
	20 PART I. Enter the diseases, or o	omplications that cause	ed the death. Do n	Ot enter the mod	de of dyling, auc	h as cardiac or reapi	ratory arrest,	Approximate	
	anock, or neert fellure. I	List only one cause on	each line.					Interval Between Onset and Daath	
	disease or condition resulting in death)	. Severe H	yro xaemi	xaemia, Metabolic acidosis				2 hours.	
	Today, in double,	DUE TO (OR AS	CONSEQUENCE OF):	- 0016 0/(2 110/3	
N	Sequentially list conditions.	, rulmonar	y filmu	200 2	o Viva	moumen	in inte		
A I		disease or condition seaulting in death) Severe Hype Xaemia, netabolic acido his Due to (or as a conscouence of): Pulmonary filmens 2° fo Viral pneumonia-1987. Due to (or as a conscouence of): Due to (or as a conscouence of):							
S cause. Enter UNDERLYING CAUSE (Disease or Injury							14-1481.	7405.	
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RTIFIC		L				production	14-1987	7 405.	
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CERTIFICATION

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DIVISION OF VITAL RECORDS, P.O. BOX 68760, 3W The NDING PHYSICIAN:

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Elementary/Secondary (0-12)

Ethel Roane

IMMEDIATE CAUSE (Final

Sequentially list conditiona,

if sny, leading to immediate cause. Enter UNDERLYING

CAUSE (Disease or Injury

that initiated events resulting in desth) LAST

3 Suicide

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director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1. DECEDENT'S NAME (First, Middle, Last) SHIELDS MELVIN 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR DAYS HOURS 230-68-1150 1X M 2 | F 46 YRS. 9a. FACILITY NAME (If not institution, give street and number) 5634 BASKET RING ROAD COLUMBIA RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION Maryland Howard Columbia 10e. STREET AND NUMBER 5634 Steven Forest Road Apt. 268 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 X Divorced Vietnam 15. DECEOENT'S EDUCATION

CERTIFICATE OF DEATH 2. DATE OF DEATH MONTH 3. TIME OF DEATH P 837 FEB 95 7. DATE OF BIRTH (Month, Dey, Year)
Aug. 10, 1948 6. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. Ohio 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH HOWARD 10d. INSIDE CITY 1 YES 2 NO 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21045 U.S.A. 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, stc.) 14. RACE — American Indian, Black, White, atc. 1 YES 2 XNO Specify: Specify: Black 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INOUSTRY (Specify only highest grade complete College (1-4 or 5+) Tax Auditor IRS 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Thomas Shielsd Evelyn Taylor 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Sister) 204 Jeffrey Drive Newport News, Virginia 23601 20s. METHOD OF DISPOSITION

(X) Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name 02-18-95 OATE 20c. LOCATION — City or Town, State Hampton Memorial Gardens Hampton, Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes 5555 Twin Knolls Road Columbia, Maryland 23. PART I. Enter the diseases, or complications that useful the detahock, or heart failure. List only one cause in each line. ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, Approximate Interval Between Onset and Death probable Preumonia days DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Heart ears Atherosclerotic Cardiovascular Disease ears DUE TO (OR AS A CONSEQUENCE OF): eary acqueite PART II. Other significant conditions contributing to death but not [saulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO cliabetes mellits. liver tailure COMPLETION OF CAUSE 1 | YES 2 | NO 1 YES 2 NO CONTRIBUTE TO CAUSE OF DEATH YES X NO 26. PLACE OF DEATH (Check only one HOSPITAL: OTHER: Inpatient 2 ER/Outpatient 3 DOA ng Home 5 K Realdenca 6 - Other (Specify) 28a. OATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO 1 YES 2 NO 26a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner ea stated. 2 W MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated, 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER · ws Me

25. WAS CASE REFERRED TO MEDICAL **EXAMINER?** 1 YES 2 NO

27. MANNER OF DEATH 1 Natural 2 Accident

29a. CERTIFIER (Check only one)

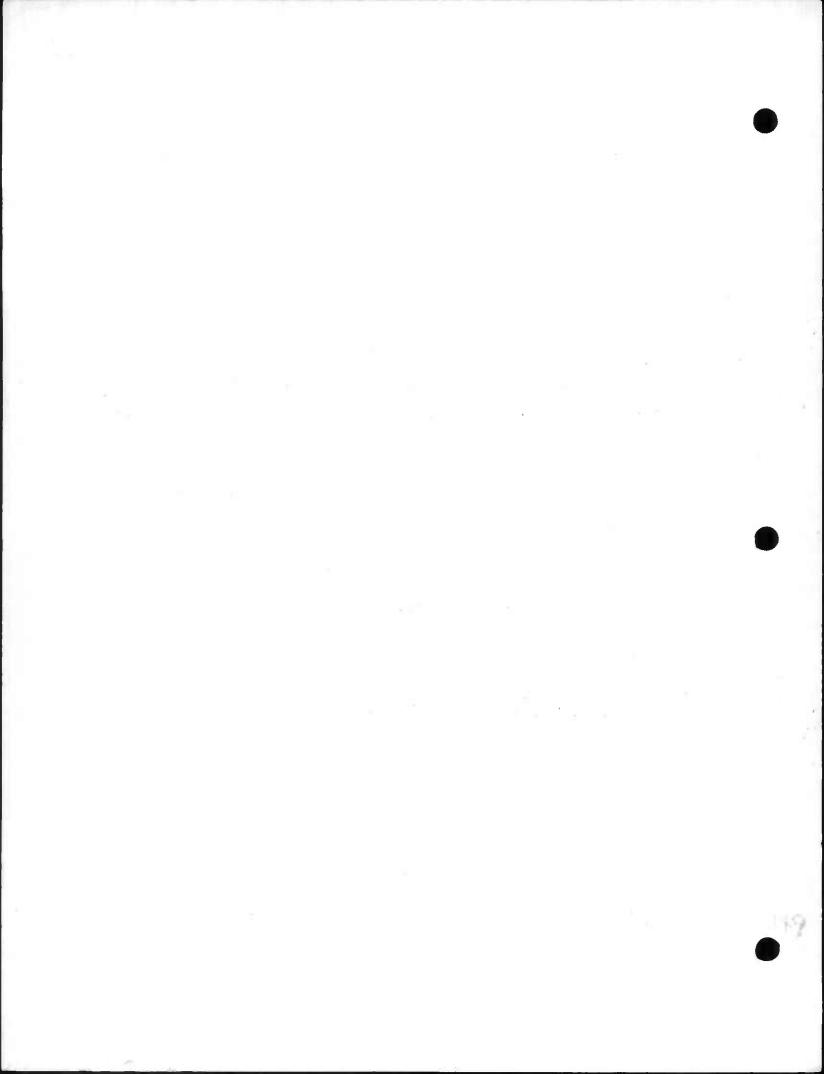
296. STOMENTURE AND TITLE OF CERTIFIER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print,

PATRYCE TOYE. 4560 HEMWCH SUL COT CITY

31. DATE FILEO (Month, Day, Year) FEB 1 6 1995





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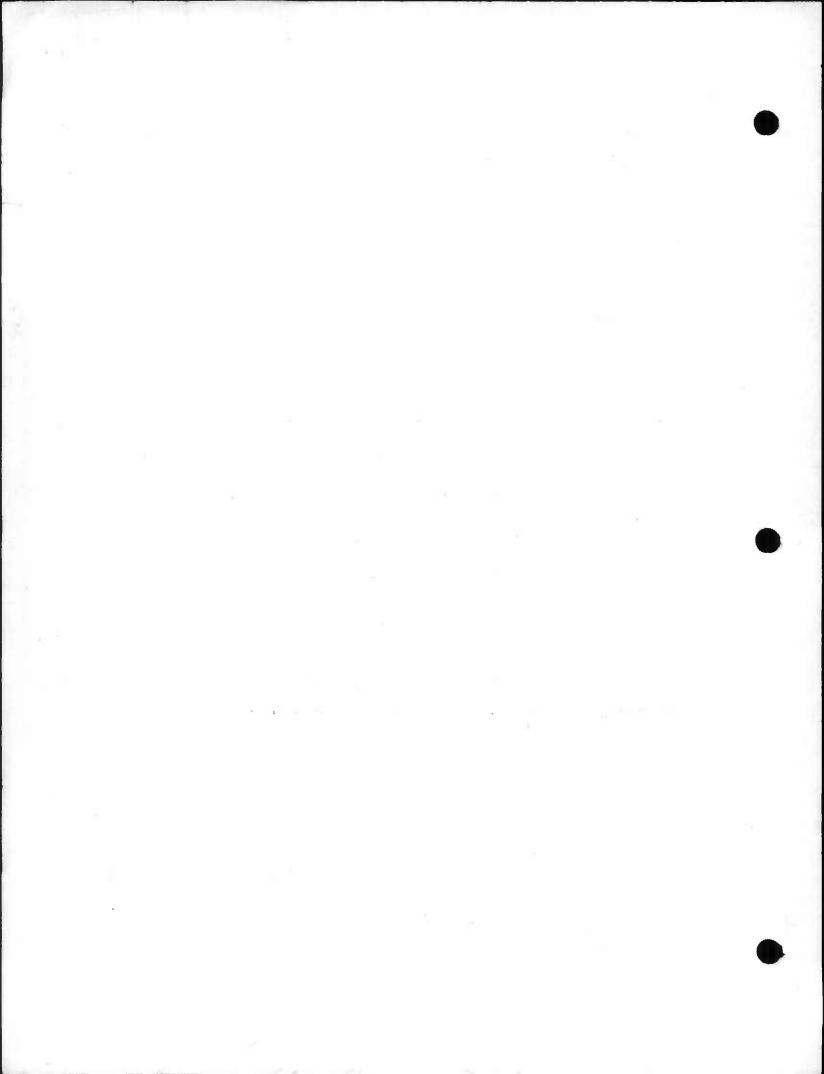
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH -95 14 Doris Smith 11:40 Am 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 7 - 21 - 21 HOURS 73 1 🗆 M 2 🖾 K YRS 12-26-2720 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Maryland General Hospital Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Baltimore CEXYES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1100 Pennsylvania Ave use as the burial-transit 21217 USA wurs after death. Page 6 may be retained by the hospital or attending physician. in by the funeral director, page 5 should be detached for use as the burial-tran 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 27 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) Specify: Black Specify: BY 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) Domestic 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Dorothy A. Myers 1631 Montello Ave. N.E. Washington, D.C. pe 20a, METHOD OF DISPOSITION
1 Durial 2 Cremation 3 Ramoval from State 20b. PLACEAND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata psnu Donation 5 Other (Specify) _ Memorial Pk Baltimore, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons Funeral Homes in by the f 1701 Laurens 23. PART Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Balto md medical shock, or heart fellure. List only one cause on each line. Interval Between cremation, or filled IMMEDIATE CAUSE (Final Onset and Death the disease or condition Cardiopulmonary Arrest unknown and completely resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): prior to burial. CERTIFICATION Sequentially list conditions, if any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF) attending physician cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 been signed by the attent. of Health and Mental PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? shows any 1 TES 2X NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES PHYSICIAN: 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item certificate h HOSPITAL:
1 Inpetient 2X ER/Outpetlent 3 DOA OTHER: 1 TES 2 NO 10 4 Nursing Home 5 Residence 8 Other (Specify) the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, With TO THE FUNERAL DIRECTOR. After this THE FUNERAL DIRECTOR After the within 72 hours after death within 72 hours aft 1 Natural 2 Accident 5 Pending Investigation 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Yown, State) COMPLETED 8 Could not be 4 Homicide determined 29e. CERTIFIER
(Check only one)

One)

MEDICAL EXAMINES: (In the heat of examination and/or larger than 1.5 miles)

MEDICAL EXAMINES: (In the heat of examination and/or larger than 1.5 miles)

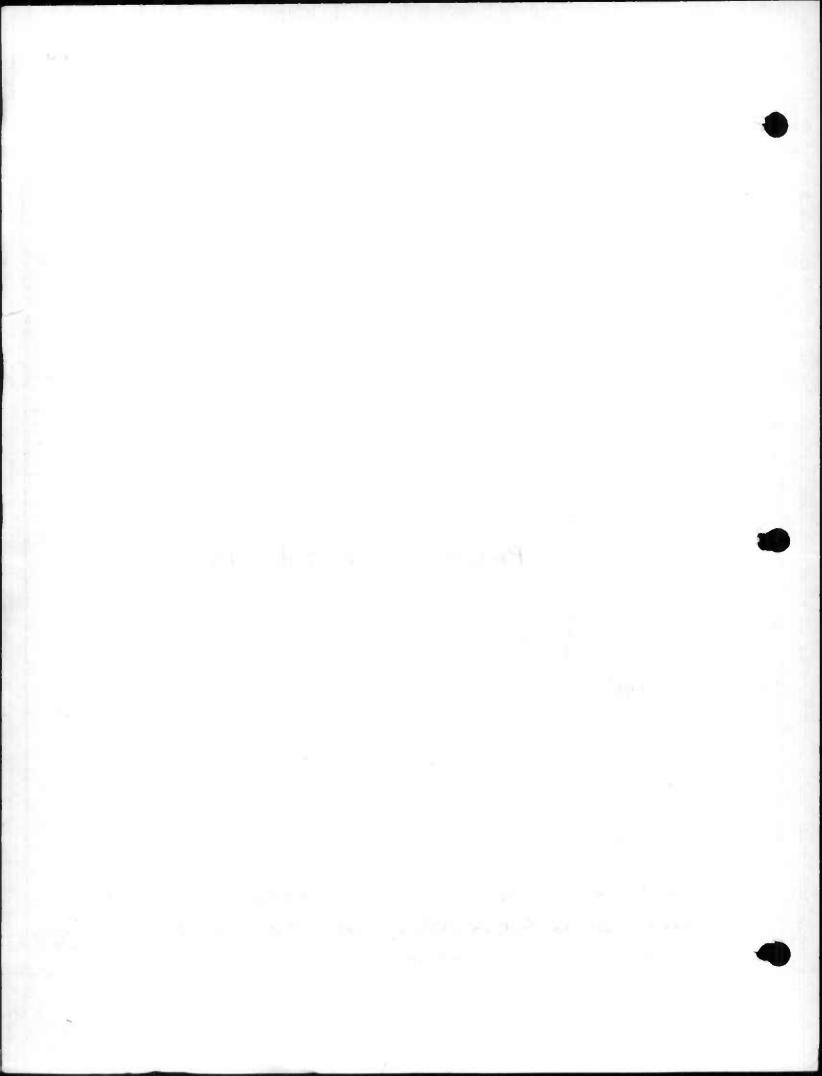
MEDICAL EXAMINES: (In the heat of examination and/or larger than 1.5 miles) 2 MEDICAL EXAMINER: On the basic of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day). 2-14-95 29c. LICENSE NUMBER 89210 Myou 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type: Print, Paiboon Siripongwishet, M.D. c/o Maryland General Hospital FEB 16 1995 Windson Randall



DHMH-16 Rev 1/89

D, BALTIMORE, MARYLAND 21215-0	thir 'ns after death. Page 6 may be retained by the hospital or attending	etely filled in by the funeral director, page 5 should be detached for use as the smation, or removal.	nt, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a siter death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	ENT OF HEALTH AND ATE OF DEATH		HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) EDDJE LOUIS	SMITH			2. DATE OF MONTH	DEATH DAY	YEAR 5	3. TIME OF DEATH		
8	4. SOCIAL SECURITY NUMBER 2.16-60-7253 9a. FACILITY NAME (If not institution, give a	1 M 2 F 40	YRS. MON	UNDER 1 YEAR IF UNDER 24 HRS THIS DAYS HOURS MIN. CITY, TOWN OR LOCATION OF	(Month, D	BIRTH ley, Year) -54	a. BIRTHI Country	YLAND		
DIRECTOR	4733 REISTERT RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT			ALTIMORE. WN OR LOCATION				10d. INSIDE CITY LIMITS?		
	MARYLAND 100. STREET AND NUMBER	LOTTIVE DO A =	BALT	TMORE 101. ZIP CODE		10g. CITIZ		1 YES 2 NO		
BY FUNERAL	4 7 3 3 REISTERT 11. MARITAL STATUS 1. Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN (FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 XNO	13. WAS DECEMBENT OF HISP If yea, specify Cuban, Maxi	can, Puarto Rice	Specify Yes or No-	Specify			
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Give kind of work of the Do NOT use reti	done during most of working red.)		ND OF BUSINESS/INDI	USTRY	ACK		
	17. FATHER'S NAME (First, Middle, Last)		2 2 0 1 1 3 1			fle, Malden Surname)	UST	K Y		
TO BE	EDGAR SMITH 19a. INFORMANT'S NAME (Type/Print)			RESS (Street and Number or Rura			Code)			
	MAXINE CARLAND 20a. METHOD OF DISPOSITION 1X Burlal 2 Cremation 3 Form 4 Donation 5 Other (Specify)	20b. P	LACE AND DATE OF DIS ery, cremetory or other p WOODLAW	lace)	DATE	MARYI.	ily or Tow	ARYLAND rn, Slata		
	21. SIGNATURE OF FUNERAL SERVICE LIC	June	1	1712 W N	PACILITY ORTH	VENILE				
	23. PART I. Enter the diseases, of ehock, or heart fellure. IMMEDIATE CAUSE (Finei disease or condition resulting in death)	a. Phe Sume	ed St	aph Ehdo	ich se cerdisc	or respiratory srre	est,	Approximate interval Batween Onset and Death		
CERTIFICATION	Sequentisily list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
PHYSICIAN: MEDICAL CE	PART II. Other aignificent condition	e contributing to deeth but	not resulting in the	e underlying couse given i		B. WAS AN AUTOPSY PERFORMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
ICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	or	26. PLACE OF DEATH (C	Check only one)					
	1 YES 2 NO									
TED BY	2 Accident Investigation 3 Suicida 8 Could not be 4 Homicide datarmined	28e. PLACE OF INJURY — building, atc. (Specify)	At home, farm, streal	M 1 YES 2 NO	28f. LOCATIO City or To	N (Street and Number own, State)	r Rural Ro	ute Number,		
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICONE) 2 MEDICAL EXAMINE	CIAN: To the beat of my knowled R: On the beale of exemination a	ige, death occurred at t	the time, data and placa, and du	e time, data and	i) and menner as state	d. cause(a)	and manner as stated.		
TO BE	29b. SIGNATURE AND TITLE OF CHITTEEN	el. MO		29c. LICENSE NO.	38	29d. DATE	SIGNED (Month, Day, Year)		
	30. NAME AND ADDRESS OF PERSON WHO ROSEH Johnson	Suite 22 /	H (ITEM 27) (Type, Print)		WA	Relieder A	lve	Baltinde		
	31. DATE FILED (Month, Day, Year) FFR 1 6 1005	32, REGISTRAR'S SIGNATI	URE	J		T. D. C. C.	/	10 ZIZIS		

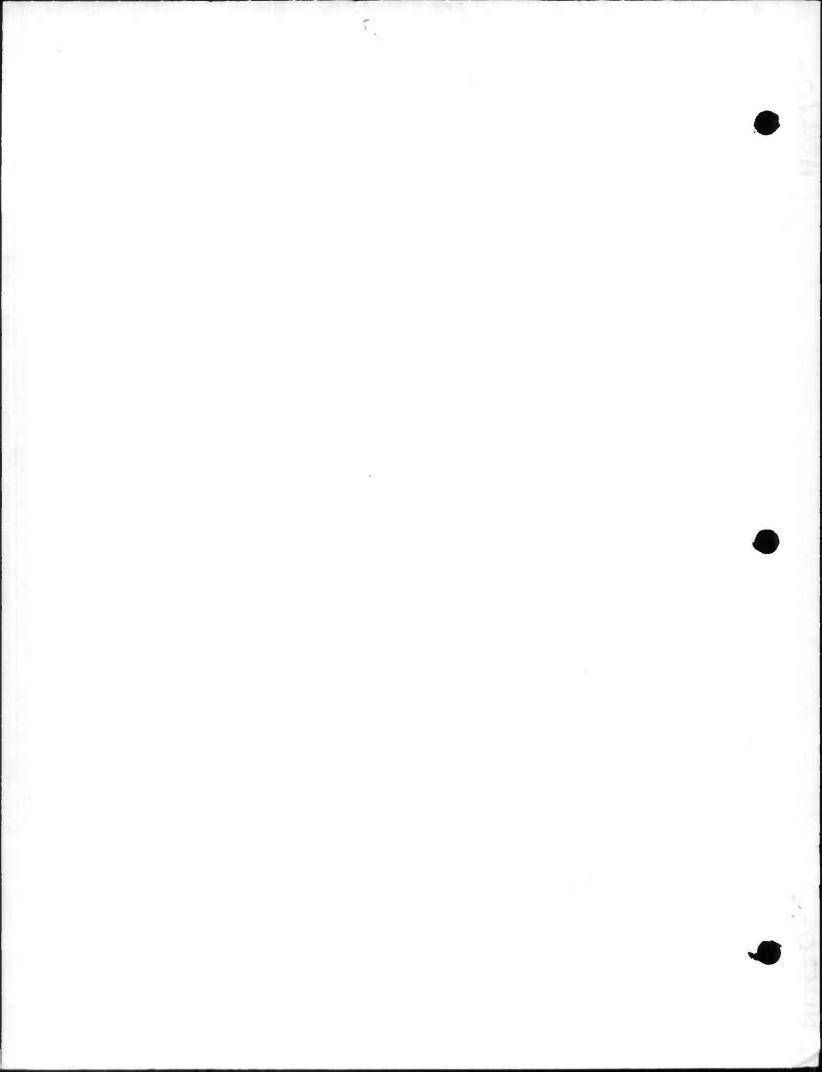


THE POSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. The hours after death. Page 6 may be retained by the hospital or attending physician.

1947HE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should follow within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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					,					95	0 !	1919
	FOR 1 - STATE REGISTRAR	STATE OF I			RTMENT				MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					. 01	DEAL		2. DATE OF DEATH		vera T	3. TIME OF OEATH
	JACK 4. SOCIAL SECURITY NUMBER	5. SEX	2.405.4		VITZ				FEBRUARY	13,	_	6:10pm м
	212-03-9597	1 M 2 F	6. AGE (In yrs. les	YRS.	IF UNDER	DAYS	HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Year) JULY 11	. 1911	Country	PLACE (State or Foreign) RYLAND
-	9e. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY,		OR LOCATIO			9c. COU	NTY OF DE	ATH
Ĕ	2711 SMITH AVE.					BAL	TIMO	RE		BA	LTIM	ORE
DIRECTOR	10a, STATE 10b, COUNTY			10c. CIT	Y, TOWN O			Б				10d. INSIDE CITY LIMITS?
	MARYLAND 100. STREET AND NUMBER	BALTI	MORE				ZIMOR			100 CITI		1 YES 2 X NO
FUNERAL	2711 SMITH AVE.							2120	9	100.011	USA	TAI COUNTY
	11. MARITAL STATUS 1 Never Married 2 Merried	FORCES? 1	T EVER IN U.S. AR	MED	i i	f yes, sp	ecify Cube	n, Mexicar	IC ORIGIN? (Specify Years, Puerto Rican, etc.)	or No-		- American Indian, White, atc.
) BY	3 Widowed 4 Divorced	IF YES, GIVE V	WAH OH DATES		'	_ YES	2 X NO	Specify			Specify	WHITE
TEC	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	completed)	(G	CEDENT'S	Work done of	CUPATIO	ON st of workin	g	16b. KIND OF BU	SINESS/IND	USTRY	
COMPLETED	12	College (1-4 or 5	-)	SALES						FUR	NITU	RE
	17. FATHER'S NAME (First, Mickelle, Caut) PHTL.1	P	SHEVITZ					ETTA	ME (First, Middle, Meiden		OCH	
70 BE	MRS. SARA SHEVIT		-	MAILING 27	ADDRESS LI SM	Smet of TH			TTMORE"," M	D SIZ1Z	.09)	
100	20s. METHOD OF DISPOSITION 1 Guital 2 Greenation 3 Rams									CATION —		rn State
	4 (1 Denation 5 (1) Deser (Specify)		compANS	By El					2-14-90	BALI	IMOR	
	21. SIGNATURE OF PUNERAL SERVICE LIC	S							N & BROS.,			0101
	23 PART I. Enter the diseases, or o	omplications the	t coused the de	ath. Do i	not enter	6010	O REI	STER	RSTOWN ROA	D BAL	TIMO	RE, MD 2121
	IMMEDIATE CAUSE (Fine)	list only one cau	ise on each line							istory and	out,	Interval Between Onset and Death
	disease or condition resulting in death)	n. Par	(OR AS A CONSEC			ses	se	se	were			20 years
N	Sequentially list conditions.).	(ON AS A CONSEC	JOENCE O	17.							
CATION	if any, leading to immediate cause. Enter UNDERLYING		(OR AS A CONSEC	EUENCE O	F):							
	CAUSE (Disease or injury that initiated events		(OR AS A CONSEC	UENCE O	F):							
CERTIF	resulting in death) LAST											
	PART II. Other algnificant conditions Arthread	contributing to	death but not re	suiting	in the un	derlying	cause g	iven in i	Pert I. 24s. WAS AN PERFOR			WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
MEDICAL		24 - 1	year 4 A	Juc	ore e	you	me.	tau	1 U YES 2	No		COMPLETION OF CAUSE OF OEATH?
N N	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEA	TH YE	S N	10 🛚	UNC	ERTAIN				1 YES 2 NO
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER	-						
PHYSICIAN:	1 U YES 2 M NO 27. MANNER OF DEATH	1 Inpatient 2 28e. DATE OF	INJURY	28b. TIM	4 🗆 Nurs	ing Home			8 Other (Specify) 28d, OESCRIBE HOW II	NJURY OCC	URFO	
286. DATE OF INJURY (Month, Dey, Year) 286. INJURY AT WORK? 1 Natural 5 Pending 1 Netural 5 Pending 2 Accident Investigation 286. DATE OF INJURY (Month, Dey, Year) 286. INJURY AT WORK? 1 YES 2 NO												
8	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE O building,	F INJURY — At hor etc. (Specify)	ne, term, s	street, facto	ery, office			281. LOCATION (Street a City or Town, Stete)	and Number	or Rural Ro	ute Number,
PLE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beet of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.											
NOC	one) 2 MEDICAL EXAMINER											end menner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	wel I	eva	か	O		29c. LICE	NSE NUM	BER 22	29d. DATE	SIGNED (Mofth, Day, Year)
0	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	SE OF DEATH (ITEM	127) (Type,	Print)	174	AV	× 1	BALTO 1	no.	212	.15
	31. DATE FILED (Month, Dey, Year) FEB 1 6 1995	32. REGISTRA	R'S SIGNATURE	100	176	11	,		~///		-	
	I O 1000											



al or attending physician. for use as the burial-transit BALTIMORE, MARYLAND 21215-0020 death. Page 6 may be retained by the hospital after BOX 68760 PHYSICIAN; The law requires that the death certificate be executed

permit. Pages 1, 2, 3 should

be detached

P.O.

OF VITAL RECORDS,

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30. NAME AND ADDRESS OF REASON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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FEB 1 6 1995

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OH: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 si	The seast with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF GEATH YEAR JOSEPH THOMAS STEWART 09:57 P FEBRUARY 1995 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign HOURS 1 M 2 D F YRS. 216-20-1410 69 01-02-1926 MARYL AND 9e. FACILITY NAME (If not Institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON tob. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND YES 2 NO BALTIMORE CITY FUNERAL tog. CITIZEN OF WHAT COUNTRY? 10e. STREET AND NUMBER 10f. ZIP CODE 2503 S. PACA STREFT 21230 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES If yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

1 YES 2/ NO Specify: 1 Never Merried 2 XXMerried 2 NO Specify: BY 3 Widowed 4 Divorced BLACK ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest g Elementary/Secondary (0-t2) College (1-4 or 5+) COMPL 7th Grade BUILDING ATTENDANT Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Morgan Stewart BE Katie Nolan too, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C.-2503 S. PACA STREET BALTIMORE, 21 MARYLAND 2 Dorothy M Stewart e 28e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Buriel 2 Donetion Burlel 2 Cremetion 3 Removal from State must 5 Other (Specify) Garrison Forest 2/21 Owings Mills, Maryland OF FUNERAL SHTYICE MCENSEE William C. Brown Community F/H Cari 1206 W North Avenue medicai 28 PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between **IMMEDIATE CAUSE (Final** Onset and Death he disease or condition resulting in death) espiratory Insur Due to (or as a congeouence of) event, Bronchospaske traumatic CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING ntestinal Hemoni DUE TO (OR AS A CONSCOUENCE OF): CAUSE (Disease or injury other that initiated events resulting in death) LAST yarteretis Nodosa 6 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL any 1 TYES 2 NO OF DEATH? Surgery for GI bleeling 1-23, 1-25, 1-26-95
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\sigma \text{NO} \sigma \text{ UNCERTAIN } \(\sigma \) 1 TYES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 1 YES 2 NO 1 M Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATH 26e. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 26b. TIME OF INJURY 28c. INJURY AT WORK? 1 Natural М t YES 2 NO ВУ 2 Accident Investigation 28e. PLACE OF INJURY — AI home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER

(Chack ank)

(CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end menner es stated. Ξ TO THE MOSP TO THE PUNER DE FIED WITHIN 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

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		HEGISTHAR		CERTIFIC	AIE U	DEATH	REG. NO.	,			
		1. DECEDENT'S NAME (First, Middle, Lest) THERESA	5. 30	SNOWS	SKI		2. DATE OF DEATH MONTH DA	AY YEAR 1996	3. TIME OF DEATH		
29		4. SOCIÁL SECURITY NUMBER 219-26-1479	5. SEX 6. AGE		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morith, Day, Year) MAKCH 3	6. BIRTH Count	HPLACE (State or Foreign		
. 2, 3 should	стов	9a. FACILITY NAME (If not institution, give st HATCOK RESIDENCE OF DECEDENT		ENTER	BA	OR LOCATION OF DE	ATH E	9c. COUNTY OF D	DEATH		
ift. Pages 1	FUNERAL DIRECT	Maryland 10b. COUNTY Maryland			timore				10d. INSIDE CITY LIMITS? X(X) YES 2 NO		
in. ransit permit,		3465 Sixth Street	t		1	01. ZIP CODE 21225		United			
215-0020 attending physician. se as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2XXNO	If yes, s	CENDENT OF HISPAN pecify Cuban, Mexical S 2/ NO Specify		44 545	E — American Indian, k, White, atc.		
	8	15. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT'S US (Give kind of work			16b. KIND OF BUS	INESS/INDUSTRY			
12 o p	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT use re	etired.)		State o	f Marylar	nd		
# 25 K	ш	17. FATHER'S NAME (First, Middle, Last) Alexander	Sosr				ME (First, Middle, Maiden ia	Surname) Jenkins			
MAR retained to 5 should	0 B	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
ORE, N 6 may be n ctor, page 5 nust be n		Mrs. Dorothy V. L(20a. METHOD OF DISPOSITION 1 Burlel 2/ Cremetton 3 Remo	206	. PLACE AND DATE OF	DISPOSITION (A	lame of	/erna Park	, Mary lar			
E 9 2		4 Donation 5 Other (Specify)	Me	etro Crema	tory,	Inc. 2/	16/95 Cate	onsville.	Maryland		
		► Len E	02	_	23/ E	· Kayapso	Home of Ave. Ba	lto. Md.	Brooklyn 21225		
within 24 hours piletely filled in b cremation, or re- rent, the medi		23. PART I. Enter the diseases, or c shock, or heert failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR AS A	A CONSEQUENCE OF:	114	KE			Approximats Interval Batween Onset and Daath		
. BOX 68 ficate be execu physician and ne prior to bur her traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	OUE TO (OR AS A CORONAL CORONA	STIVE	HE,	ART.	FAILU	PE			
S, P.O e death certi he attending Mental Hygie jury, or off						,		24			
SCORE signed by the signed by	MEDICAL	PART II. Other significent condition	3/FEMO			2 - 1 - 9 1	PERFOR	MED?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
> P -:	ä	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YES	□ NO [UNCERTAIN					
上年 8 8 5	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 KNO	HOSPITAL:		THER:						
OF PHYSIC this cer with th	PHYSICIAN:	27. MANNER OF DEATH 1 Natural 5 Pending	Inpatient 2 ER/Outp	28b. TIME O	F 28c. IN	JURY AT ORK? YES 2 NO	8 Other (Specify) 28d. DESCRIBE HOW IN	JURY OCCURED			
ISIC TTENDI TTENDI TTOR: A after d	TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, atc. (Spec	/ — At home, farm, street			281. LOCATION (Street a City or Town, State)	nd Number or Rural F	Route Number,		
DI AL OR LE DIRE	COMPLET		EAN: To the best of my know								
TO THE HOSPITAL TO THE FUNERAL De filed within 72 i	BE CO	296. SIGNATURE AND TITLE OF CENTIFIER	1110	Transfer investigation,		29c. LICENSE NUM		29d. DATE SIGNEO			
6 6 % W	10	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF DE	ATH (ITEM 27) (Type, Pri		10289	88	77-1	0-99		
		31. DATE FILED (Month, Dey, Year) EED 1 5 1000	32. REGISTRAR'S SIGN	ATURE	300	1 5. HA	HOVER	5 21	BALT:		
6		FEB 1 5 1995	John Danden	" Kudalli			,				

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DIVISION OF VITAL RECORDS,	The state of the s
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Nours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

FOR

	1 - FOR STATE REGISTRAR	TATE OF MARYLAND	/ DEPART	MENT OF H	EALTH AND DEATH	MENTA	L HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last) ABE SCHOOLSE					2. DATE MONT	OF DEATH		YEAR 3	THE OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SI	EX 6. AGE (In yrs. II		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	1	B. BIRTHPLA	CE (Steps or Foreign
	222 00 0727 2	km²□F 91	YRS.	MONTHS DAYS	HOURS MIN.	JUNE	27,19	903		ZLAND
œ	9a. FACILITY NAME (If not institution, give street ar	96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNT BALTIMORE							Y OF OEATI	1
210	LEVINDALE RESIDENCE OF DECEDENT			BAL'	'IMORE					
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	3520				100	I. INSIDE CITY LIMITS?
	MARYLAND 10e. STREET AND NUMBER					TIMOR	E			YES 2 NO
RA	1190 W. NORTHERN PA	מוסג עגועסא	21.4	101	ZIP CODE	0101	^			COUNTRY?
FUNERAL	11. MARITAL STATUS 12 V	MS DECEDENT EVER IN HE	PMED	13. WAS DEC	ENGENT OF HISPA	2121	17 (Specify Yes		ISA 4. BACE —	American Indian.
BY F	1 Never Merried 2 Merried If	FORCES? 1 YES 2 X	NO	If yes, sp	2 NO Specific	an, Puerto I	Rican, etc.)		Black, Wi Specify:	nite, etc.
	15. DECEDENT'S EDUCATION									WHITE
	(Specify only highest grade comple	eted) (Give kind of wo fe. Do NOT use	ISUAL OCCUPATION ork done during monetimed.)	ON st of working	18b	. KIND OF BUS	INESS/INDU	STRY	
1PL	5+	ege (1-4 or 5+)	VIC	CE PRESI	DENT		FINANC	E.		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, I				
BE (JOSEPH		CHLOSS		MOL					
2	19e. INFORMANT'S NAME (Type/Print)	1			nd Number or Rural					21210
.	MRS. MINNIE SCHLOSS 20a. METHOD OF DISPOSITION									, MD21215
	t □XBuriel 2 □ Cremelion 3 □ Removal fr 4 □ Donetion 5 □ Other (Specify)	om State cometary c	THOYJAC	FDISPOSITION (Na COBCO)		2-15-	95 FIN	ATION — CH		
	21. SIGNATURE OF FUNERAL SERVICE LICENSES				D ADDRESS OF FA				0, 12	
	· Seatt 11	1 wille							TMODE	, MD 21219
	23. PART I. Enter the diseases, or compliance, or heart fallure. List o	ications that caused the d	laath. Do no							Approximata
	IMMEDIATE CAUSE /Final								j	Interval Between Onset and Desth
	disesse or condition resulting in death)	ROBABLE	MYO	CARDIA	FF 14	FAR	1100	7		1 HOUR
_	_	DUE TO (OR AS A CONSEQUENCE OF):								
<u>ē</u>	Sequantially list conditions, if any, lasding to immediate	DUE TO (OR AS A CONSEQUENCE OF):								
CA	Cause. Enter UNDERLYING CAUSE (Disease or Injury	DHE TO OR AS A CONSEQUENCE OF								
TIF	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSE	S A CONSEQUENCE OF):							
CERTIFICATION	d									
	PART II. Other significant conditions con					Part I.	24a. WAS AN / PERFORI			RE AUTOPSY FINDINGS
Ö	HISTORY OF T	KHNZIFNT	IZCHF	MIC A	TIACI-		1 TES 2	X.NO	CON	MPLETION OF CAUSE DEATH?
M	DID TOPACCO LIST CONTRIBUTE	TE TO CAUSE OF DE	ATIL VEC					, ,	1 [YES 2 NO
AN	DID TOBACCO USE CONTRIBU			(Check only one)	UNCERTAI	ΝЦ				
SIC		SPITAL: Inpatient 2 ER/Outpatient		QTHER:	5 - Realdenca	8 Other	(Specify)			
PHYSICIAN: MEDICAL		28e, DATE OF INJURY (Month, Day, Year)	28b, TIME INJU	OF 28c. INJ	JRY AT	_	CRIBE HOW IN	JURY OCCU	RED	
BY	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆 Y	ES 2 NO					
	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY — AI h- building, etc. (Specify)	ome, iarm, str	reet, factory, office		281. LOCA	ATION (Street ar or Town, State)	nd Number or	Rural Route	Number,
COMPLETED	29a. CERTIFIER			2010/2010			2 - 11 - 11			
MP		To the best of my knowledge, d								
	29b. SIGNATURE AND TITLE OF CERTIFIER						end piace, end			
BE	THE ST SERVICE	9	PENDI	- 1	D 25 6	MBER		Z9d. DATE S		oth, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WHO COM	PLETED CAUSE OF DEATH (ITE	EM 27) (Type, F	Print) SET		40		ď.	(cho -	7.7
	LEVINDALE 2434	WEST BELV	er de		11 (00	BAL	IMOF	REM	nn :	11215
		32. REGISTRAR'S SIGNATURE						120		
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BALTIMORE, MARYLAND	retained
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Pages 1, 2, 3 should

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notified

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medical examiner

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or other traumatic event,

or Item 23 shows any Injury,

CERTIFICATION

PHYSTCTAN: MEDICAL

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COMPLETED

BE 2 IMMEDIATE CAUSE (Final

disease or condition

resulting in death)

4 Homicide

tal or attending physician. 21215-0020 detached for 2 funeral director, page 5 should filled in by the fullon, or removal. ö l completely filled irial, cremation, a certificate has been signed by the attending physician and com TO THE HOSPITAL OR ATTENDING PHYSICIAN The law requires that TO THE FUNERAL DIRECTIOR: After this certifications be filed within 72 hours after death with the CHARLOPED. Of Health an IMPORTANT: If Item 28 is marked or Item 23 shows any

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	FOR STATE REGISTRAR		STATE OF I	MARYL	AND /	DEPAR	TMEN'	OF H	EALTH DEA	AND I	MENTAL HYGIEI REG. NO				
	1. OECEDENT'S NAME (First	, Middle, Last)									2. DATE OF DEATH			3. TIME OF DEATH	
	Ronald (Gene	Setle	r. Sı	r.							12,19	YEAR		M
	4. SOCIAL SECURITY NUME	BER	5. SEX		In yrs. lest	birthday)	IF UNDER	1 YEAR	IF UNDER		7. DATE OF BIRTH	12,13	8. BIRTI	HPLACE (State or Foreign	
	219 38 6364		1 ⊋ M 2 □ F		50	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Ybar)	1044	Count		
	9a. FACILITY NAME (If not institution, give street end number)						9b. CITY	TOWN C	R LOCATI	ON OF DE	SEDL. II.		WEST	Virginia	
Œ	John Hopkins Bayview Medical Cen					270			ore			30.000	, , , , , , , , , , , , , , , , , , ,	LAIT	
읝	RESIDENCE OF DEC	EDENT	rew Medit	ai (Jenice	ST	Da	TCIII	ore	CILLY					
Ĕ I	10a. STATE 10b. COUNTY 10c. C						TY, TOWN OR LOCATION 10d. INSIDE CITY								
DIRECTOR	Maryland –						Bal	timo	re					LIMITS?	
A	10e. STREET AND NUMBER							101	ZIP COD	E		10g. CIT	IZEN OF	WHAT COUNTRY?	_
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BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo	Merried	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 X N			. WAS DECENOENT OF HISPANIC If yes, specify Cuben, Mexicen, 1 YES 2 NO Specify:			IIC ORIGIN? (Specify Yea or No— 14, RAC n, Puerto Rican, etc.) 149			E — American Indien, k, Whita, atc.	
COMPLETED		EDENT'S EDU			(Gh	6e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retire).)					_				
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0 0	17. FATHER'S NAME (First, M	iddle, Last)			IICILI	recin	MICC.	I ICC.			ME (First, Middle, Maide		Ombi	EX	_
BE C	Ruby Walter	Setle	r, Jr.							rtha		Surrienner			
	19a. INFORMANT'S NAME (7	ype/Print)			19b.	MAILING	ADDRESS	(Street a	nd Number	or Rural A	loute Number, City or To	vn, Statu, Zi	p Code)		
2	Donna M. Set	ler									Baltimore			6	
	20a. METHOD OF DISPOSITI 1 Burtel 2 □ Crematio 4 □ Donation 5 □ Other	n 3 🗆 Rem (Specify)	De Adec Communication	20b. cem HC	PLACE A	NDDATE	OF DISPOS	ITION (Na	me of			CATION -	City or Tr	wn State	
	31, SIGNATURE OF FUNERAL	L SEMMOE LIC	ENSEE	1			22.	NAME AN	O ADDRE	S OF FAC	uneral Hor				

DUE TO (OR AS A CONSEQUENCE OF): Acute Myocardial Infarction (anterior) Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate . Enter UNDERLYING Coronary Artery Disease CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO I UNCERTAIN I

Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest,

1407 Eastern Ave Baltimore Maryland 21221

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL:

1 X inputient 2 - ER/Outputient 3 - DOA OTHER: 1 - YES 2 X NO 4 🗌 Ni Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO 5 Pending Investigation 1 X Natural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Chack ank) 1 (X CERTIFVINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner es stated. (Check only one)

2 MEDICAL EXAMINER: On the beste of examination end/or investig	pation, in my opinion, death occured at the time, date end place.	, end due to the ceuse(s) and menner ee stated.
96. SIGNATURE AND TITLE OF CERTIFIER	29c LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)

BO. SIGNATURE AND TITLE OF CERTIFIER		295 LICENSE NU	70		29d. DATE S	15/0	15.
D. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	John	Hopkins	Bayv	iew Me	edical	Cer	nter
EDWITED D. SHADIRD	4940	Fastern	Δυσ	Ralti	more	Md	2122/

31. DATFFEED MONTH, Pay, 1995 32. REGISTRAR'S SIGNATURE

6 Could not be

shock, or heart failure. List only one cause on each line.

. Cardiac Arrest

Approximate

interval Between

Onest and Death

DIVISION OF VITAL RECORDS, P.O. BOX 68769

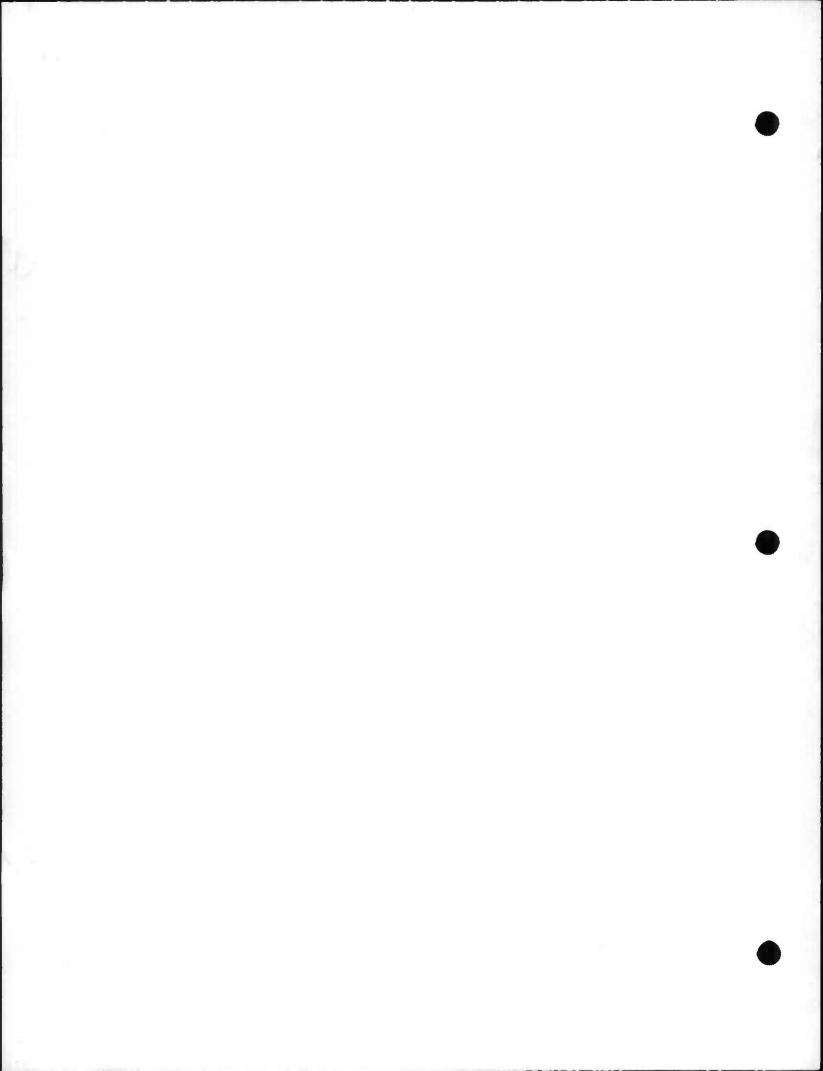
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	FOR STATE REGISTRAR		STATE OF M							MENTA		_		
		Middle, Last)				IOAII		DEA		2. DATE				3. TIME OF DEATH
	James	Fran	cis	SM	ITH					Feb	ruary	14,1	995	2:55 P M
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs. I	asl birthday)					7 DATE	OF BIRTH		a BIRTHI	PLACE (State or Foreign
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						9b. CITY	, TOWN O	R LOCATI	ON OF DE				A	ATH
6			Hospi	tal		Re	ossv	ill	е			Ва	1timo	re
띱	10e. STATE				10c, CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY
胎	Maryland	Balt:	imore				Esse	x						LIMITS?
A P	10e. STREET AND NUMBER						101.	ZIP CODE	E			10g. CIT	TIZEN OF W	
띮	8 Pecan Driv	<i>r</i> e						212	21			U.	S.A.	
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. A	RMED							or No-	14. RACE	- American Indian, White, atc.
					JNO						Rican, etc.)		Specifi	<i>(</i> :
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	(Specify only	highest grade	completed)		Give kind of	work done	during mos	st of working	g	166	b. KIND OF BU	SINESS/IN	DUSTRY	
<u> </u>	12	-12)	College (1-4 or 5 4	"	Gu	ard					Sec	urit	v Con	npany
Š	17. FATHER'S NAME (First, Mi	iddle, Last)						18. MOTI	HER'S NAM	ME (First,	-		1	r 2
اسا	James Smith	1						Man	ude					
-				F	R 1,	Box	1912	, Ne	scope	eck	PA.,	1863	5	
	4 Burlel 2 Cremetlo	ON n 3 ☐ Remo	oval from State	20b. PLACI cemetery, c	rematory or c	OF DISPOS	ITION (Na	me of	2/	DAT	20c, LO			
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l	The second second	12		51		B	ruzd	zins	ki F	iner	al Hom	e P.	A.	
\vdash	na	12	700	1		14	07 C	ld E	aste	rn A	ve.,Ba	lt.	, MD	,21221
	shock, or he	seasea, or c aart fallure. I	omplications the list only one cau	t caused tha d ise on aach ilr	ieath. Do i ia.	not antar	tha mod	da of dyl	ng, such	ss can	diac or reapi	ratory ar	rest,	Approximate Interval Between
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	resulting in death) DUE TO (OR AS A CONSEQUENCE OF):												1 day	
_	Sensis													
흔	Sequentially list conditions, If any, leading to immediate Sepsis Oue TO (OR AS A CONSEQUENCE OF):													
8	Trany, trading to immediate cause. Enter UNDERLYING													
틸	that initiated eventa		DUE TO	(OR AS A CONS	EOUENCE O	F):								
	Tooding III death) CAS		l											
			contributing to	death but not	reaulting	in tha ur	derlying	cauaa g	lvan in i	Part I.				WERE AUTOPSY FINDINGS
일	Prolonged a	anoxia												AVAILABLE PRIOR TO COMPLETION OF CAUSE
WE												A.A	- 1	OF DEATN? 1 YES 2 NO
	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF DE	ATH Y	S 🔲 I	NO 🗆	UNC	ERTAIN	1 🔯				
S	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26. PL/	CE OF DEA									
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		Pending					WOR	RK?	,	28d. DE	SCRIBE NOW I	NJURY OC	CURED	
	2 Accident	nvestigation	28e PLACE O	F IN HIDY At h	ome fem	trant fam			NO	*** 00				
9			building,	atc. (Specify)	onne, regin,	ATOOI, IOCI	ory, office	,		City	or Town, State)	ind Numbe	r or Hural Ho	ute Number,
E	290, CERTIFIER	IEVING BUVEIG	MAN. To the heat of									/2000 m	97.1	
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임	20 NAME AND ADORESS OF		COMPLETED CAUS	E OF DEATH (IT	EM 27) (Type	Print)							-//7	113
	BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION TO BE (1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, James) 4. SOCIAL SECURITY NUMBE 042-07-805 90. FACILITY NAME (If not in Franklin Seesidence of Decide 100. STATE Maryland 100. STREET AND NUMBER 8 Pecan Driv. 11. MARITAL STATUS 1 Never Merried 2 Seesidenty (In 12 Never Merried 2 Seesidenty on 12 Never Merried 2 Seesidenty (In 12 Never Merried 2 Seesidenty on 12 Never Merried 2 Seesidenty on 12 Never Merried 2 Seesidenty on 12 Never Merried 2 Seesidenty on 12 Never Merried 2 Seesidenty on 12 Never Merried 2 Seesidenty on 12 Never Merried 2 Seesidenty on 12 Never Merried 2 Seesidenty on 12 Never Merried 2 Seesidenty on 12 Seesident	1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) James France 4. SOCIAL SECURITY NUMBER 042-07-8058 99. FACILITY NAME (III not institution, give state) Franklin Square RESIDENCE OF DECEDENT 100. STATE 100. COUNTY Maryland Balt: 100. STATE 100. COUNTY Maryland Balt: 100. STATE 100. COUNTY Maryland Balt: 11 Never Merried 2 Merried 12 Merried 13 Wildowed 4 Divorced 15. DECEDENT'S EDUC (Specify) only highest grade Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Last) James Smith 199. INFORMANT'S NAME (Type/Print) Charlene R. Samse. 209. METNOD OF DISPOSITION 4 Burlei 2 Cremetion 3 Remed 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE 15. SEQUENTIAL SERVICE LICE 16. SEQUENTIAL SERVICE LICE 17. FATHER'S NAME (First, Middle, Last) 199. INFORMANT'S NAME (Type/Print) Charlene R. Samse. 209. METNOD OF DISPOSITION 21. SIGNATURE OF FUNERAL SERVICE LICE 23. PART I. Enter the diseases, or condition resulting in death) NOULTO STATE 199. INFORMANT'S NAME (First, Middle, Last) 199. INFORMANT'S NAME (Type/Print) Charlene R. Samse. 200. METNOD OF DISPOSITION 4 Burlei 2 Cremetion 3 Remed 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE 24. SIGNATURE OF FUNERAL SERVICE LICE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. CERTIFIER (Check only only 1) 27. MANNER OF DEATH 28. Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 290. CERTIFIER (Check only only 2 MEDICAL EXAMINER 290. SIGNATURE AND TITLE OF CERTIFIER 25. MEDICAL EXAMINER 26. CERTIFIER (Check only only 2 MEDICAL EXAMINER 27. MEDICAL EXAMINER 28. SIGNATURE AND TITLE OF CERTIFIER 28. MEDICAL EXAMINER 290. SIGNATURE AND TITLE OF CERTIFIER	1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) James Francis 4. SOCIAL SECURITY NUMBER O 42 - 07 - 80 58 90. FACILITY NAME (If not institution, give street and number) Franklin Square Hospi Fiesidence of decedent 100. STATE 100. STATE 100. STATE 100. STATE 100. STATE 100. STATE 100. STATE 100. STATE 100. STATE 100. STATE 100. STATE 100. STATE 100. STATE 100. STATE 100. STATE 100. STATE 100. COUNTY Maryland Baltimore 100. STREET AND NUMBER 8 Pecan Drive 11. MARITAL STATUS 1	1. DECEDENT'S NAME (First, Middin, Last) James Francis SM 4. SOCIAL SECURITY NUMBER 0. 4. SOCIAL SECURITY NUMBER 1. DECEDENT'S NAME (First, Middin, physe street and number) Franklin Square Hospital Franklin Square Hospital RESIDENCE OF DECEDENT 100. STATE 100. COUNTY Maryland 11. MARITAL STATUS 11. Merer Merried 12. WAS DECEDENT EVER IN U.S. A FORCEST I LIX YES 2 [14. Yes, CUVE WAN ON DAY 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16. LE Ementary/Secondary (6-12) 17. FATHER'S NAME (First, Middin, Last) James Smith 190. NFORMANT'S NAME (TypePrint) Charlene R. Samsel 20. PLACE 23. PARTI I. Enter the diseasea, or complications that caused the chock, or hard feilure. List only one cause on sach if MMEDIATE CAUSE (Finel disease or condition resulting in death) 23. PARTI II. Enter the diseasea, or complications that caused the chock, or hard feilure. List only one cause on sach if MMEDIATE CAUSE (Finel disease or condition resulting in death) 23. PARTI II. Enter the diseasea, or complications that caused the chock, or hard feilure. List only one cause on sach if MMEDIATE CAUSE (Finel disease or condition resulting in death) 23. PARTI II. Other aignificant conditions contributing to death but not Prolonged anoxia DID TOBACCO USE CONTRIBUTE TO CAUSE OF DE. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1	1. DECEDENT'S NAME (First, Micking, Last) James Francis SMITH 4. SOCIAL SECURITY NUMBER 0. 42 - 0.7 - 80.58 9. FRACILITY NAME (if not institution, give street and number) Franklin Square Hospital RESIDENCE OF DECEDENT 100. STATE 101. STATE 102. STATE 103. STATE 104. COUNTY Maryland 105. STATE 106. COUNTY Baltimore 106. COTH Maryland 107. STATE 108. STATE 108. SOUNTY Baltimore 109. STATE 1	1. STATE S	1. STATE 1. DECERDATE AND RAME (First, Mickobs, Last) James Francis SMITH 4. SOCIAL SECURITY NUMBER 0.42-07-8058	STATE OF MAINTENANCE OF PEAN LESS	STATE SAME Francis SMITH SMI	TREGISTRAR 1. DECEDENT'S NAME (**)*** (Addis, Last) James Francis SMITH 4. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (19 yr. last portion) Franklin Square Hospital Rossville Franklin Square Hospital ROSSVIlle Franklin ROSSVIlle	1. DECEMBETT HAME (Part, Modes, Land) James Francis SMITH 4. SOCIAL SECURITY HAME (Part, Modes, Land) James Francis SMITH 5. SOCIAL SECURITY HAME (Part, Modes, Land) James Francis SMITH 5. SOCIAL SECURITY HAME (Part, Modes, Land) Franklin Square Hospital 7. Trush Similar Square Hospital Franklin Hospital Franklin Hospital Franklin Hospital Franklin Hospital Franklin Hospital Franklin Hospital Franklin Hospital Franklin Hospital Franklin Hospital Franklin Hospital Franklin Hospital Franklin Hospital Franklin Hospital Franklin Hospital F	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE DOCTOR DOC	THE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR LOCKDESTRAR FIRST AND AND AND AND AND AND AND AND AND AND

Dr. Kumar Dalla 9000 Franklin Square Dr. Baltimore, Maryland 21237

31. DATE FILEO (NORTH, Day, Your)

FEB 16 1895



		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	RTMENT OF I	HEALTH AND	MENTAL HYGIE			11	
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	DAY	YEAR 3.	TIME OF DEATH	
	8	BEULAH-F. SHOCKE					FEB 11	1995)	5:00A M	
pin		4. SOCIAL SECURITY NUMBER 219-03-8958	1 🗆 M 2 💢 F	(In yrs. lest birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		1920	Country) Marv	land	
1, 2, 3 should	стоя	98. FACILITY NAME (If not institution, give standard MORTH ARUNDEL HOS		IATION	GLEN B	URNIE	PEATH	ANNE			
Pages	DIRE	10s. STATE 16b. COUNTY	ne Arundel	10c. CIT	Y, TOWN OR LOCA Millers				100	d. INSIDE CITY LIMITS? YES 25 NO	
n. ansit permit.	FUNERAL	104. STREET AND NUMBER 239 SEVERN	Road,		10	1. ZIP CODE	.108	10g. CITIZE		T COUNTRY?	
215-0020 attending physician. se as the burial-transit	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR O	2-NO	II yes, sp		NIC ORIGIN? (Specify Year, Puerto Rican, stc.)	es or No 14	I. RACE Black, W Specify:	American Indian, hita, etc. White	
	밀	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	(Give kind of	USUAL OCCUPATION	ON est of working	16b. KIND OF B	USINESS/INDUS	TRY		
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YLAN by the hos be detach at once,		17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAM							
NRYI ned by build be	BE	Marshall 198. INFORMANT'S NAME (Type/Print)	Me	cCabe	ADDOCCO (C)	Daisy					
	5	Mr. Lester B. Sho	ockey, Sr.	1239	112		Route Number, City or To		,	. 21108	
FOR e 6 ma ector, g		20e. METHOD OF DISPOSITION 1 Surface 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	oval from State cen	PLACE AND DATE	ther plecel		oate 20c. L	kland.			
		21. SIGNATURE OF FUNERAL SERVICE LIC	Kevin E	. Ecker	MCCU 3204	lly Fune Mountai	eral Home In Rd., Pa	of Pasa sadena	adena , Md.		
tely fille mation,		IMMEDIATE CAUSE (Finel	omplications that caused list only one cause on a distribution of the cause on a distribution of the cause of	ach line.		1.	ch as cardiac or rea	piratory arrea	ł,	Approximate Interval Between Onset and Death 24 Lichts	
N 8 5 - 6	N	Sequentially list conditions,	A . 1 .		2					24 lours	
e be es sician a nior to traum	CATIC	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury C. Alzheimers Dementic)									
P.O. th certificanding p Hygien or othe	CERTIFICATION	that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):								years	
ORDS that the d ed by the th and Mer any injur	AL	PART II. Other algnificent conditions	contributing to death b	ut not resulting	in the underlying	g cause given in	Part I. 24a. WAS A PERFO	PRMED?	AWA	RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION DF CAUSE	
PE v requi been s tr. of H	4: MEDIC	DID TOBACCO USE CONTR	RIBUTE TO CAUSE O	F DEATH YE	S I NO I	UNCERTAI	N IZ			DEATH?	
has has	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEAT		OTTOLKIA			<u> </u>		
VIT.	YSIC	1 TES 2 AND	HOSPITAL: 1 Inputiont 2 ER/Outp	atient 3 DOA	OTHER: 4 Nursing Hom	e 5 🗆 Residence	8 Other (Specify)				
NO OF VI NG PHYSICIAN: ther this certifica eath with the St marked, or it	ву Рн	27. MANNER OF DEATH 1 Wittural 5 Pending 2 Accident Investigation	28a. OATE OF INJURY (Month, Day, Year)	28b. TIM INJ	URY WO	URY AT RK? 'ES 2 NO	28d. DESCRIBE HOW	INJURY OCCUP	ED		
ISIC TTEND TTOR: A after d after d	ETED E	3 Suicida 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, atc. (Spec	— At home, ferm, (street, fectory, office	at, factory, office 28t. LOCATION (Street City or Town, Steet			t and Number or Rural Route Number, e)		
世 322 世	COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC One) 2 MEDICAL EXAMINER	CIAN: To the best of my knowl t: On the besis of examination	edge, death occurre	ed at the time, data n, in my opinion, d	and place, and due	to the cause(s) and mo	inner as stated.	ause(a) and	d manner as stated.	
岩 岩 岩 色	뀖	296. SIGNATURE AND TURE OF CENTIFIER	Prus -	29c. LICENSE N				29d. DATE SI	GNED (Mor	nth, Day, Year)	
P P 3 W	٩			COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)				122 > 2/4/95			
		S1. DATE FILES (MODIL), DAY, MARY, TEB 16 1995	M.D. #206 203 P. REGISTRAR'S SIGN ALLA DAUGION		AL DRIVE	, GLEN E	SURNIE, MD	21061			
1		FD T 0 1999									

ittending physician. se as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

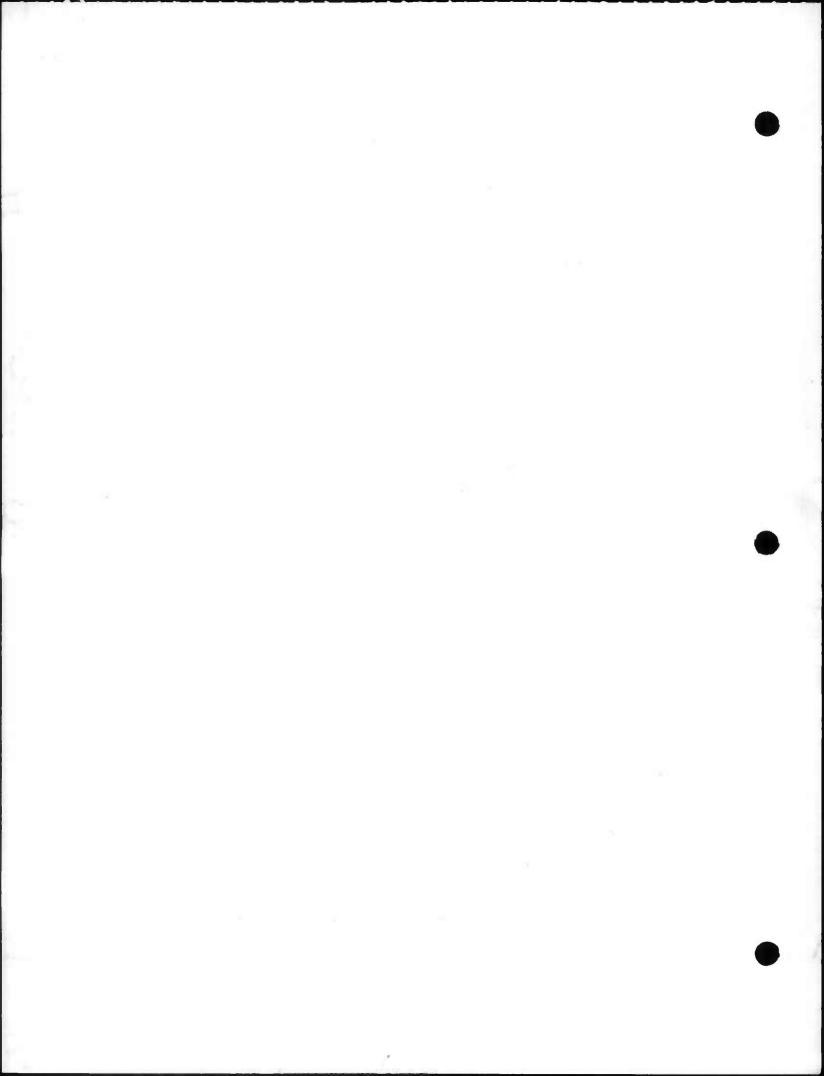
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	he	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for	e D
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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed	TO THE FUNERAL DIRECTOR: After this cert	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.	
ECEDENT'S NAME (First, Middle, Last)		2 DATE OF DEATH	-

		1 - STATE REGISTRAR	.05	STATE OF N		/ DEPAF ERTIF					ENTAL HYGIEN REG. NO			
		1. DECEDENT'S NAME (First, I	Middle, Last)	Helen 1	L. Togno	occhi					E DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE	12	YEAR	. TIME OF DEATN
		4. SOCIAL SECURITY NUMBE 213-18-9807		5. SEX 1 M 2 F	6. AGE (In yrs. Ia	et birthday) YRS.	IF UNDE	R 1 YEAR	IF UNDER		DATE OF BIRTH (Month, Day, Year) 06/22/19		8. BIRTNPL Country)	ACE (State or Foreign
	~	9a. FACILITY NAME (If not inst	_	_	12		9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF					NTY OF DEA	TN	
	CTOR	8170 Kavana	agn Ro	pad			Dundalk Baltimore							re
	DIRE		10b. COUNT	Baltimo		10c. CIT	y, town or location Dundal			71-			Od. INSIDE CITY	
		Maryland 100. STREET AND NUMBER		ватешю	re			101	ZIP COD		.LK	10a. CIT		YES 2 NO
	VERAL	8170 Kavana	agh Ro	oad						2	1222	Un	ited	States
	BY FUN	11. MARITAL STATUS 1 Never Married 2 N 3 Widowed 4 Divorce		YES 2 NO If yes, specify Cuben, Mexican				n, Mexican, !	n, Puerto Rican, etc.) Black, White			- American Indian, White, etc. White		
		15. DECE	DENT'S EDU	18e. Di	ECEDENT'S	USUAL C	CCUPATIO	N		16b. KIND OF BUS	BINESS/INC	DUSTRY	7111100	
	LET	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)						during mos	et of workin	ng	_			
Once	COMPLE	12 Years 17. FATHER'S NAME (First, Mid	Sale	s		18. MOTI	IED'S NAME	(First, Middle, Maiden	etail					
- 65	BE C	James Murphy								lma W		Surrierrey		
	2	19a. INFORMANT'S NAME (Typ	,		19						te Number, City or Tow			
		Mark W. Too	ON		20b. PLACE		_			. Ba	ltimore,		21214	Plate
E I		Surfet 2 Cremation 3 Removal from State complete, crematory of other (Specify) Gdns. of Faith Cem. 02/15/1995 Dorsey, MD								i, State				
examiner must		21. SIGNATURE OF FURERAL		I	Duda-	Ruck		ral Home			•			
medical	7922 Wise Ave. Dundalk, MD 2 22. PART I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, where the figure is tell only one cause on each life.										212 rest,	Approximata		
event, the me		Interval									Interval Between Onset and Death			
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING													
y, or other	CERTIF	that initiated events resulting in death) LAST	l	d	(OR AS A CONSE	OUENCE O	F):							
any inju	CAL	PART II. Other algnificant	t condition	s contributing to	death but not	reaulting	In the u	nderlying	ceuse g	iven in Pa	rt i. 24a. WAS AN PERFOR	MED?	AA O	ERE AUTOPSY FINDINGS AILABLE PRIOR TO OMPLETION OF CAUSE
2	MED													F DEATH?
1 23 1	PHYSICIAN:	DID TOBACCO US 25. WAS CASE REFERRED TO		RIBUTE TO CA		TH YE			UNC	ERTAIN				
or Item	SIC	EXAMINER?	2.000	HOSPITAL:			OTHE	R:	5 (1) Ra	sidence 8 [Other (Specify)			
	BY PHI	27. MANNER OF DEATN 1 Natural 5 Pe 2 Accident Im	ending westigation	28e. DATE OF (Month, O	INJURY ay, Year)	28b. TIM INJ	E OF URY M	28c. INJU WOI 1 Y	JRY AT RK? ES 2		ad. DESCRIBE HOW II	NJURY OC	CURED	
28 is	ETED		ould not be elermined	28a. PLACE Of building,	F INJURY — At ho etc. (Specify)	ome, farm, s	itreet, lac	tory, office		28	Rf. LOCATION (Street e City or Town, Stete)	and Number	or Rural Rou	te Number,
2 2	COMPLE										the cause(e) end man			nd menner ae stated.
PORT	IO BE	396. SIGNATURE AND TITLE OF CENTIFIER							290 LICE	THE NUMBER	ER (24)	29d. DATI	E SIGNED (M	lonth, Day, Year)
	KWANG H LEE, 100 N. B.							rad	wa	7.	Balta	un	R I	4231
1		31. DATE FILED (Month, Dey, Ye.	6 199!		R'S SIGNATURE	indelle								

		REGISTRAR		CERI	IFICATE	OF DEATH	REG.			
		1. DECEDENT'S NAME (First, Middle, Last)	: 11.	Toom	0. 1		2. DATE OF OEATI	DAY	YEAR	TIME OF OEATH
11.0		1 helma /	- 1 / (10(P)	E (In yrs. lest birtho			2			10:10 A M
		215-16-5716			MONTHS	1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yea	r)	8. BIRTHPL/ Country)	ACE (State or Foreign
Pin		July 04, 1923								ryland
3 should	~	Harford Memorial				TOWN OR LOCATION OF E				Н
2,	DIRECTOR	RESIDENCE OF DECEDENT	nospitai		1	Havre De Gra	ace	Har	ford	
es 1,	E	10a. STATE 10b. COUNT	Υ	10c.	CITY, TOWN O	PR LOCATION			10	d. INSIDE CITY
Pa.	등	Maryland Har	ford	100		Havre De (Grace		-	LIMITS? YES 2 NO
permit. Pages		10e. STREET AND NUMBER				101. ZIP CODE		10a, CITIZ		T COUNTRY?
	FUNERAL	302 Robin Hood F	Road		21078				USA	
020 physician. burtal-transit	3	11. MARITAL STATUS	R IN U.S. ARMED 13. WAS DECENDENT OF HISPAN			NIC ORIGIN? (Specifi		14. BACE — American Indian.		
		1 Never Married 2 Married	FORCES? 1 YE	DATES NO	2 NO If yes, specify Cuban, Maxica)	14. RACE — American Indian, Black, White, atc. Specify:	
o ing	ВУ	3 X Widowed 4 Divorced			The specific				Whi	to
AND 21215-0 the hospital or attending detached for use as the once.	ED	15. DECEDENT'S EDU (Specify only highest grade		18a. DECEOEI	IT'S USUAL OC	CCUPATION during most of working	16b, KIND OF	BUSINESS/INDU		
21 21 20 m	<u>=</u>	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life Do No	Of use retired.)	Juling most of working				
ND 2 hospital ached to	MP I	5th		Homema	aker		Own :	Home		
AN the hox detach	COMPLET	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S N	AME (First, Middle, Ma	iden Surname)		
d be	ш	Boswell Wal	ter			Ruth	Knight			
MARYLAND retained by the hospit should be detached notified at once.	TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAI	ING AOORESS	(Street and Number or Rural	Route Number, City or	Town, State, Zip C	Code)	
	F	Rome Walter Knigh	ıt	302	Robin	Hood Rd. I	Havre De	Grace,	MD 21	.078
BALTIMORE, or death, Page 6 may be the funeral director, page val.		20s. METHOD OF DISPOSITION 1 Durial 2 2 Cremation 3 Ram		20b. PLACE AND DA	TE OF DISPOSI			LOCATION — CI		
T ecto	1	4 ☐ Donalion 15 ☐ Other (Specify)		emetery, crematory Metro C1	or other piece) emator	y, Inc. 02	2/15/95 B	altimor	e. MT)
ALTIM death, Page funeral dire		21. SIGNATURE OF FUNERAL SERVICE LI	Dawn F.	McDona]	ط 22. ا	NAME AND AGORESS OF F	ACILITY			
		> Glining 1	las knald			cemation Soc				
By safter of the by the removal.		23. PART i. Enter the diseases, or	complications that cause	sed the death. I	o not enter	99 Frederick	c Rd. Ba	Ltimore	MD	21228 Approximata
hours after od in by th or remove		shock, or haart failure.	List only one cause or	each iina.	2	,,,,,,	1	/		interval Batween
		disease or condition (a () to)								Onsat and Daath
d within 24 ompletely fille cremation, the event, the	1	resulting in death)	81. DUE TO (OR A)	S A CONSEQUENC	5.05	/	000	1-6		na
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OX 68: e be execute sician and c nior to buria traumatic	CERTIFICATION	Sequentially list conditions,	OUE TO (OR A	S A CONSEQUENC	E OFI:					
trau rior i	¥	if any, leading to immediate cause. Enter UNDERLYING								
ine phy	E	CAUSE (Disease or Injury that initiated evanta DUE TO (OR AS A CONSEQUENCE OF):								
P.O. ending I Hygie	E	resulting in death) LAST	4							
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ORDS, that the deal ed by the att th and Menta any injury,	EDICAL	PART II. Other algnificant condition	ns contributing to death	byt not resulti	ng in the un	derlying cause given is		FORMED?		RE AUTOPSY FINDINGS MLABLE PRIOR TO
COR res that igned by ealth an	8	- Vous	r oh	100	150	uce 4	1016	2 2 NO		MPLETION DF CAUSE DEATH?
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1 2 00		DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH	YES D	NO W UNCERTA	IN 🔲 📗			
	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF						
SIAN: Triffica	YSI	1 WES 2 NO	1 Inpetient 2 ER/O	utpatient 3 🗆 DO	A 4 Nurs	ing Home 5 🗆 Residence	8 Other (Specify)			
2 2 2 2	PHY	27. MANNER OF DEATH	26a. DATE OF INJUR (Month, Day, Year		TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HO	W INJURY OCCU	JRED	
ON OD OING PHYS After this death with s marked	B	1 Natural 5 Pending 2 Accident Investigation			M	1 YES 2 NO				
0 5 4 5 6		3 Suicida 6 Could not be	28a. PLACE OF INJU building, etc. (S	RY — Al home, fair pecify)	m, street, lacto	ory, office	28f. LOCATION (Str City or Town, S	eet and Number o	r Rural Route	Number,
OR ATTEN OR ATTEN DIRECTOR: hours after Item 28 I	ETE	4 Homicide datermined								
DIV L OREC L DIREC L DIREC L DOURS	MPLI	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of my kn	owledge, death oc	curred at the til	me, data and place, and du	s to the cause(s) and	manner as states	d.	
HISPITAL FLNERAL Thin 72 I	COM	one) 2 MEDICAL EXAMINE	R: On the basis of examina	tion and/or investig	pation, in my op	pinion, death occured at the	e time, data and place	, and dua lo the	cause(a) an	d manner as stated.
BTA BTA		290. SIGNATURE AND TITLE OF CENTIFIE	10	1		29c. LICENSE NU	MBER	29d. DATE	SIGNED (Mo	onth, Day Year)
TO THE HUSPI TO THE FUNER be filed within IMPORTANT:	BE O	11 de	won	fr	M	2140	36	▶ 2	8/14	0198
/	51	O NAME AND ADDRESS OF PERSON WI	O COMPLETEO CAUSE OF	OEATH (ITEM 27) (Type, Print)				/ - /	
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

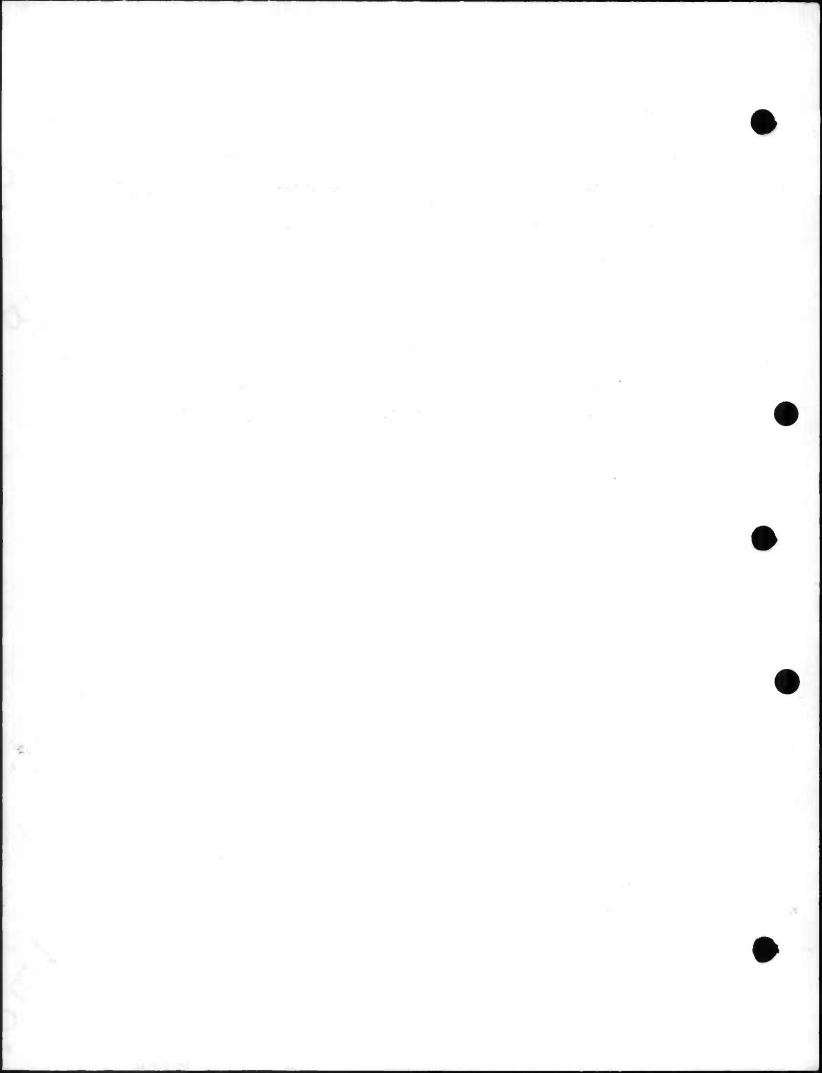


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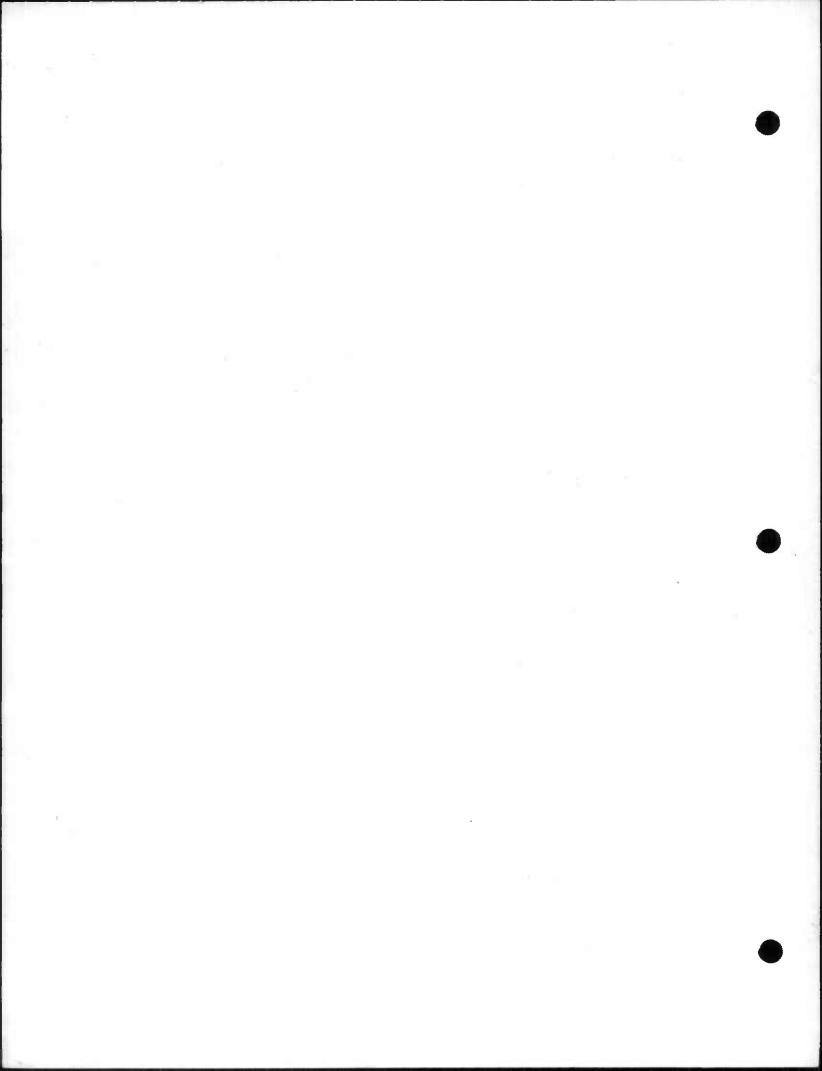
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	TO THE HOSPITAL OR ATTENDED BY THE FIGURE. The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or	TO THE FINE BALL DIRECTOR ATTENT OF CONTRICATE HAS been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for	tate [IMPORTANT. If them 28 is marked, of item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR		STATE OF I		/ DEPAF					MENT	AL HYGIEI			
		V-	Tolor							2. DAT	TE OF DEATH	DAY	YEAR 9	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMB 217-46-0439		5. SEX	8. AGE (In yrs. 67	last birthday) YRS.	MONTHS DAVE		IF UNDER	R 24 HRS. MIN.	7. DATE OF BIRTI (Month, Day, Ye NOV. 14		1927	Country	PLACE (State or Foreign Pryland
OR	90. FACILITY NAME (II not in Northwest H	ospita			96. CITY, TOWN OR LOCATION OF DE				eath 8c. county of death Baltimore					
DIRECTOR	RESIDENCE OF DEC	10b. COUNTY Balt		10c. CIT	Y. TOWN OF			1	1				10d. INSIDE CITY LIMITS? 1 YES 2 X NO	
FUNERAL	16. STREET AND NUMBER			. 1-D	D 101. ZIP CODE 2 1 1 3 6			10g. CITIZEN OF W				THAT COUNTRY?		
B≺	11. MARITAL STATUS 1 Never Married 2 X 3 Widowed 4 Divo	Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	T EVER IN U.S.				en, Puerto Rican, stc.) Blaci			14. RACE Black	- American Indian, White, atc.		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE				16b. KIND OF BUSINESS/INDUSTRY			ŢĢ.		
BE CO	17. FATHER'S NAME (FIRST, M. Samuel B.		r								, Middle, Maide Lginia		2.11	
TO B	19a. INFORMANT'S NAME (7)	ypa/Print)						nd Numbe	r or Rural	Flourte Nu	mber, City or To	wn, State, Z	ip Code)	*******
	Albert E. T 20. METHOD OF DISPOSITI 1X Burial 2 Cormatio	ION on 3 Remo	oval from State	20b. PLAC	EAND DATE	16 Brookbury Dr. Apt. 1D Reisterstown, Md. 21136 AND DATE OF DISPOSITION (Norme of party of String place) OATE OF Place of ix Markell and						, Md.21136 wn, State		
	1x Burial 2 Cremation 3 Removal from State Cappetery, gremetory of other place Cemetery 2-1,6-95 Phoenix, Maryland								own Road					
CERTIFICATION	23. PART I. Enter the di ahock, pr h- iMMEDIATE CAUSE (Fin disease or condition reaulting in death) Sequentielly list conditi if eny, leeding to immer cause. Enter UNDERLYI CAUSE (Disease or injuthat initiated events resulting in death) LAS	iona, diate	DUE TO	use on each il	SEQUENCE O	FI:			ing, suc	h as ce	rdiec or res	piratory a	rrest,	Approximate interval Between Onset and Death
PHYSICIAN: MEDICAL C	PART II. Other significa	t resulting in tha underlying cause given in i				Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO			24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
ICIA	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:			OTHER	1:		EATH (Ch					
	27. MANNER OF DEATH 1 Netural 5	Pending Investigation	28e. DATE OF (Month, D	INJURY	28b. TIN		28c. INJ WC				her (Specify) ESCRIBE HOW	INJURY O	CORED	<u> </u>
TED BY	2 Accident 3 Suicide 8 Homicide	home, farm,	street, facto	ory, offic	•			CATION (Streetly or Town, State		er or Rural R	loute Number,			
COMPLETE			CIAN: To the best of Fi: On the basis of a) and manner as stated.
TO BE C	296. SIGNATURE AND TITLE	- 1	15inl					29c. LIC	ENSE NUI	WBER	44397	29d, DA	TE SIGNED	(Month, Day, Year)
	30. NAME AND ADDRESS OF	STA IT	completed CAU		TEM 27) (Type 75 Le		. 1	id						
	FEB 1 6 199	5 Jul	32. REGISTRA	AR'S SIGNATURE										



1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		OLITHIOATE OF BEATH	REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last) PRTSY WELLING CHUS	2. DATE OF DEATH	3. TIME OF DEATH	Н
		1. 121.24 C COLCIGIAS	1213	95 1108	AM
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthdey) IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Fore	reign
9		213-30-2096 1 M 2 F 59 YRS. MONTHS DAYS HOURS MIN.	August 9	1935 Country 5 .C.	
should		Be. FACILITY NAME (If not institution, give about and number). 9b. CITY, TOWN OR LOCATION OF C		9c. COUNTY OF DEATH	
2, 3	O B	Northwest Hospital Balto			
—	DIRECTOR	RESIDENCE OF DECEDENT 104. STATE 10b. COUNTY 166. CITY TOURS OF LOCATION			
Pages	2	10a. STATE 10b. COUNTY 10c. CITY, 764/N OR LOCATION	1	10d. INSIDE CITY LIMITS?	_
permit, I		1119 Daito Randalis	own	1 🗆 YES 2 💢	100
	\%	100. STREET AND NUMBER 101. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
ransh	ij.	13121 Courtleigh Dr. 2113	3	U.S.A.	
020 physician. burlal-transit	FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AMMED 13. WAS DECENDENT OF HISPA FORCES? 1 YES 2 NO If yes, specify Cuban, Maxic		or No- 14, RACE — American Indian Black, White, etc.	n,
fing ph	ВУ	3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Spec		Specify: Q	,
21215-0020 If or attending physic for use as the burial	ED			17/10/04	_
or ath	TE	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working	16b. KIND OF BUS	INESS/INDUSTRY	
	COMPLET	Elementary/Secondary (6-12) College (1-4 or 5+) life. Do NOT use retired.)	6	15. 10	1 '
AND the hospital detached for	M	14rs 41R	Socia	Security A	an,
/LA by the be det			AME (First, Middle, Maiden		
RYL ed by uld be	BE	John Wesley Campbell lestel	ena Z	dwards	
MARYLAND retained by the hospit 5 should be defached notified at once.	2	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural	1 - 12		
		Fluon WIRINS 2121 Courtiel	gh Dr. 13	alto, md 2113	3
BALTIMORE, I after death. Page 6 may be by the funeral director, page 8 movel.		20. METHOD OF DISPOSITION 1 Squriel 2 Cremetion 3 Removel from State 2 Donation 5 Other (Specify)	DATE 20c. LO	CATION — City or Town, State	/
LTIMOR ath. Page 6 ma meral director, p meliner must		107631001	11/49 6	Wings Mills,	mod
ALTIN death. Pag tuneral dis f. examiner		21. SIGNATURE OF BONERAL SERVICE LICENSEE	C. H-Wes	st	
BALTIM after death. Page by the funeral direct moval.		1 Actia Chian 4300 h	la bash	Ave	
nours after d in by th or remove		23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, au	ch as cardiac or reaple		
	- 1	ahock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Fine)		Interval Bet Onset and	
		disease or condition	Y C W	Rac 1 12H	
3760 rted within completely ial, cremati event, t		DUE TO (OR AS A CONSEQUENCE OF):	,	3	
CB760 executed with and comple o burlal, cres matic even	z			1"	
OX 68: e be execute sician and confor to burial	은	Sequentielly list conditions, If any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):			
BOX ficate be a physician and ne prior to	3	ceuse. Enter UNDERLYING CAUSE (Disease or Injury			
.O. B. certificate ding physiene pringlene pri	E	that initiated events OUE TO (OR AS A CONSEQUENCE OF):			
D = 5 = 0	CERTIFICATION	resulting in death) LAST			
	1	PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in			
CORDS, res that the de signed by the at leatth and Ment we any Injury.	MEDICAL	The state of the s	Part I. 24a. WAS AN . PERFOR	MED? AMAILABLE PRIOR TO	O
ECOR wires that signed by Health an	ă		1 🗆 YES 2	OMPLETION OF CA	WSE
교 등 등 등	2			1 - YES 2 - NO	0
AL RECOR e law requires that has been signed by Dept. of Health an 23 shows any	Ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DOUNCERTAIN	N 🗆		
T # # # E	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER:			
PHYSICIAN: The this certificate with the State riked, or item	YSI	1 YES NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence	6 Other (Specify)		
OF PHYSIC this ce with th	표	27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK?	28d. DESCRIBE HOW IN	JURY OCCURED	
	ВУ	1 Netural 5 Pending 2 Accident Investigation M 1 YES 2 NO			
NOING NOING R: After r: death		3 Suicide 6 Could not be 28a. PLACE OF INJURY — At home, lerm, street, factory, offica building, atc. (Specify)	281. LOCATION (Street a City or Town, State)	nd Number or Rural Route Number,	
DIVISION OR ATTENDING F DIRECTOR: After Murs after death tem 28 is mar	ETE	4 Homicide determined	City or lown, State)		
DIV OR A DIREC Mours	١٣	29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and dur	to the councie) and man		
3 36 =	COMPL	(Check only one) 2 MEDICAL EXAMINER: On the beals of axamination and/or investigation, in my opinion, death occurred at the			d. d
IN THE HOSP TO THE FUNE SO MPORTANT:		AND ENGINEERING STATES			ned.
1 1 2	B	29c. LICENSE NU	0 -	29d. DATE SIGNED (Month, Day, Year)	
FFSE	2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)	5599	> 2-1395	
		M & CONTROL COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)	22711	P 00 n.	
		31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE		· new IN	, >
L		FEB 1 6 1995 junt arandon Randall			



BALTIMORE, MARYLAND 21215-0020

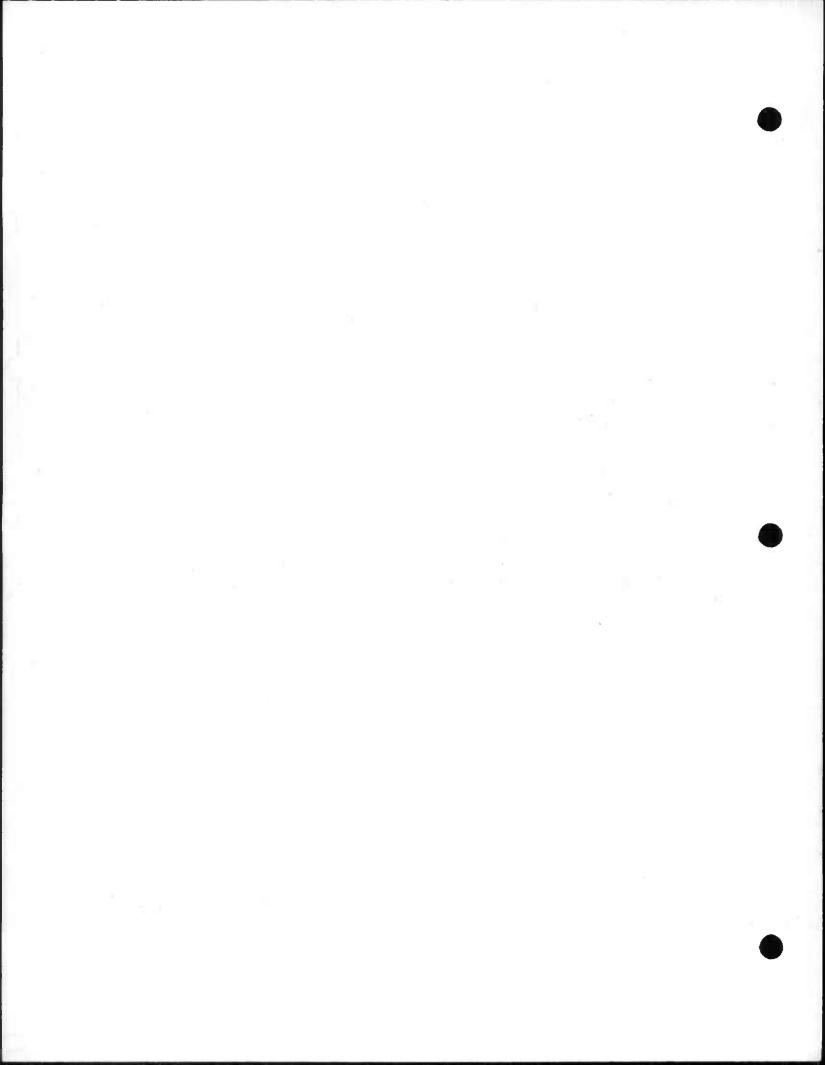
DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

).			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	MY YE	3. TIME OF DEATH		
	LOUIS	Р.		OODFO	LK Sr.	FEB 1		5 11:45		
	4. SOCIAL SECURITY NUMBER 211-20-8941	5. SEX 1 M 2 F 6.	AGE (In yrs. last birthday) VRS.	MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year)	1929	NRTHPLACE (State or Foreign		
	9e. FACILITY NAME (If not institution, give str	reet and number)		9b. CITY, TOW	N OR LOCATION OF D		9c. COUNTY	OF DEATH		
DIRECTOR	UNIVERSITY S.T.	U.		BALT	IMORE CI	TY				
IRE	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWNOR LOS	11-			10d. INSIDE CITY		
	10e. STREET AND NUMBER	. 0.1		-	101. ZIP CODE		10g. CIŢIZĘN	1 N YES 2 NO OF WHAT COUNTRY?		
FUNERAL	4816 Bonn	ie Kidi	ge Dr.	102	212	09	u	SIA		
	1 Never Married 2 Married	12. WAS DECEDENT EX FORCES? 1 I	YES 2 NO	If yes,	SECENDENT OF HISPA specify Cuben, Maxic ES 2 A NO Speci	NIC ORIGIN? (Specify Ye an, Puarto Rican, atc.) fv:		RACE — American Indian, Black, White, etc. Specify: // /		
ED BY	3 Widowed 4 Divorced							Valack		
131	15. DECEDENT'S EDUC (Specify only highest grade of	completed)	16a. DECEDENT'S (Give kind of v	work done during		16b. KIND OF BU	SINESS/INDUST	RY		
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Crane	475	ator	Bethl	ehem	Steel		
00	17. FATHER'S NAME (First, Middle, Last)	1 10 1	12		18. MOTHER'S NA	AME (First, Middle, Maider	(Sumeme)			
BE	190 INFORMANT'S NAME (Type/Print)	10001+01	K 100 MAN 110	1000500 (0)		esa	Dog	ey,		
2	Denise	1. Wor	odfolk	1502	L ak	Route Numbes City or Tov	n, State ZID Cod	21218		
	20e. METHOD OF DISPOSITION 1	ovni from State	20b. PLACE AND DATE OF PROPERTY OF PROPERT	of DISPOSITION	(Neme of Preten	78/9 S 1	1100	or Town, State		
	21. SIGNATURE CY FUMERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 23. NAME AND ADDRESS OF FACILITY 24. NAME AND ADDRESS OF FACILITY 25. NAME AND ADDRESS OF FACILITY 26. NAME AND ADDRESS OF FACILITY									
	Portia	J Core	m	2	1300 W	Julaish	Ave			
	23. PART I. Enter the diseases, or co ahock, or heart feilure. L	omplications that ca	used the desth. Do n	ot enter the r	node of dying, suc	h ss cardisc or resp	iratory srrest,	Approximate		
	IMMEDIATE CAUSE (Finei	.ist only blie ceuse i	on eech line.					Onset and D		
	disease or condition resulting in death)	Moune	WE THISURY	ध्र				ļ		
		DUE TO (OR	AS A CONSEQUENCE OF	ት :						
CERTIFICATION	Sequentially list conditions,	DUE TO (OR	AS A CONSEQUENCE OF	F):						
8	if any, leading to Immediate cause. Enter UNDERLYING									
뜯	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):									
J 77 11								1		
	thet initiated events resulting in death) LAST	i								
		ı	oth but not resulting i	n the underly	ing ceuse given in	Part I. 24s. WAS AN				
	resulting in death) LAST	ı	oth but not resulting i	n the underly	ing couse given in	Part I. 24e. WAS AN PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUS		
MEDICAL	PART II. Other significent conditions	s contributing to dee				PERFO	RMED?	AVAILABLE PRIOR TO		
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FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
1. DECEDENT'S NAME (First Middle Last)		

		REGISTRAR		CERTIF	ICATE OF	DEATH		REG. NO.				
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH		3, 7	TIME OF DEATH	-
		JEROME		W	EINBER	G	MONTH	DAY	3 51	4 P	12:15P	
		4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(In yrs. lest birthday)			FF	B				М
		The state of the s	X M 2 D F 72		IF UNDER 1 YEAR	HOURS MIN.		DE BIRTH Day, Year)	8. B	HRTHPLAC Country)	CE (State or Foreign	
모				YRS.			NOV		1922	M	ARYLAND	
should		9a. FACILITY NAME (If not institution, give s	street and number)		9b. CITY, TOWN	OR LOCATION OF D	DEATH		9c. COUNTY C			
ro en	ا د	5715 PARK HEIGHTS AVE. APT.807 BALTIMORE CITY										
1, 2,	5	RESIDENCE OF DECEDENT										_
Pages	DIRECTO	10a. STATE 10b. COUNT	Υ		TY, TOWN OR LOC	ATION				10d.	INSIDE CITY	
ب م	<u>=</u>	MARYLAND		BALTIMORE				10			LIMITS?	
permit.	1	10e. STREET AND NUMBER			1	Of. ZIP CODE		T	10g. CITIZEN (1 41		_
	8	5715 PARK HEIGHTS	AVE., APT.	807		21215		i	USA	or what	COOKINI	
020 physician. burial-transit	FUNERAL	11. MARITAL STATUS										
215-0020 attending physician se as the burial-trai	E	1X Never Married 2 Married	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	N U.S. ARMED		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea of If yea, specify Cuben, Mexican, Puerto Rican, etc.)				RACE - A Black, Wh	merican Indian,	
the bu	BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES		S TO NO Speci			s	Specify:		
as th			1						WI	HITE		
		15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(Give kind of	WORK done during it	ION lost of working	16b.	KIND OF BUSI	NESS/INDUSTR	₹Y		
		Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT u	se retired.)	•			100			
ND 2 hospital ached for	₽	12		DELIVER	KYMAN		L	LITTMAN DENTAL			PPLY CO.	
MARYLAND retained by the hospit 5 should be detached notified at once.	COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, N	liddle, Maiden S	umame)			
4 P T	Ш	FRANK I. WE	INBERG			LILL			,	COH	EN	
Band Day	00	19a. INFORMANT'S NAME (Type/Print)		405 44411 1016	A D D D T D D C C C C C C C C C C C C C C							_
MAR retained 5 should notified	유					and Number or Rural						
		MRS. JEAN LILLI		3606	CLARINT	H RD., A	PT. 1	-D BAL	10., MI	D 2	1215	
BALTIMORE, I er death. Page 6 may be the funeral director, page val.		20n. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Rem	aval from State	PLACE AND DATE	OF DISPOSITION (A		DATE	1	ATION - City o		itata	
OR ma		4 Donation 8 Other (Specify)	Cen	NAI ISRA	FT 2	15 1005	1	DATE	10., MI	D		
Page Il dire		21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	TWILL IDIO.	22. NAME /	AND ADDRESS OF FA	ACILITY	DAL.	IO. / PIL			_
ALTIN death. Pag tuneral dis funeral dis examiner		D. a. a. a.				EVINSON		S. TNO	G			
		ullinsi	le Devis	noon		REISTERT				MD	21215	
es aft		23. PART I. Entar tha diseases, or	complications that cause	d tha death. Do i	not antar tha m	oda of dying, au	ch as card	ac or reapire	story arrest.	1	Approximata	-
5		shock, or haart fallure.	List only one cause on a	ach Ilna.						- 1	Intarval Between	
10 mg		IMMEDIATE CAUSE (Final disease or condition	V				10.4	-			Onset and Deati	n
within 24 npletely fille cremation,	1 1	resulting in death)	" RAMALOS	LEROTTE	COMO	gum 2 au	n DI	SEA 76				
secured within 24 and completely fill burial, cremation, matic event, the			DUE TO (OR AS A	CONSEQUENCE O	F):							_
	z	Commence of the control of the contr	b									
	[일]	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEGUENCE O	F):							-
ta prior grice	8	cause. Entar UNDERLYING CAUSE (Disease or Injury										
, P.O. BOX leath certificate be e attending physician mal Hygiene prior to y, or other traum	CERTIFICATION	that initiated events DUE TO (OR AS A CONSEQUENCE OF):								-+		-
P.O. th certification and ing Hygier or oth		resulting in death) LAST										
	믱		d									_
0 9 4 2 4		PART II. Other algnificant condition	a contributing to death b	out not reaulting	in the underlyin	ng cause given in	Part I.	24a. WAS AN AI	UTOPSY	24b. WER	E AUTOPSY FINDINGS	
	EDICAL							PERFORM			LABLE PRIOR TO	
CO ires the signed lealth a								1 YES 2			EATH?	
T S SI	N N							TUPE	Mon	1 [YES 2 NO	
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VITAL JAN: The faw tificate has I e State Dept or item 23	SICIAN	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEA	TH (Check only one)						_
/ITA	100	EXAMINER? 1 YES 2 □ NO	HOSPITAL: 1 Inpatient 2 ER/Outs	atlant 3 DOA	OTHER:	me 5X Residence	0 0 00					_
. O 5 5 -	РНҮ	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TiM		JURY AT	7		Harry Occupant			_
TSION OF VITA TENDING PHYSICIAN: The TOR: After this certificate h after death with the State [28 is marked, or item		1 Natural 5 Pending	(Month, Day, Year)		JURY W	ORK?	200. DE\$	NIBE HOW INJ	JURY OCCURED	,		
ON DING After death	E I	2 Accident Investigation				YES 2 NO						
OIVISION OR ATTENDING DIRECTOR: After nours after death	a	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	' — At home, ferm, i	street, factory, offi	co	281. LOCA City o	TION (Street and Town, State)	d Number or Rui	rel Route I	Number,	
ATT ATT S ath S ath S ath S ath		4 Homicide datermined										
DIVISION OR ATTENDING I DIRECTOR: After hours after death item 28 is mai	COMPLET	29a. CERTIFIER 1 CERTIFYINO PHYSI	CIAN: To the best of my know	lados dasth occurs	ad at the time, det	e and place and due	to the new	-(a) and				
	Σ		R On the basis of examination									
OSF UNE ANT	8	A		- and or involvingation	ni, in my opinion,	Death occured at the	r IIIIe, Gata	and place, and	due to the caus	se(s) end	menner as stated.	
# # # B	ш	29b. MANUFIE AND TITLE OF CERTIFIER	1/ 1/2			29c. LICENSE NU			29d. DATE SIGN			٦
TO THE HOSPITAL TO THE FUNERAL De filed within 72 h IMPORTANT: If it	В	will single will	MND			O.C.M	.E.		▶ FEB	. 1	4/95	
FFQE	9	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type	. Print)							4
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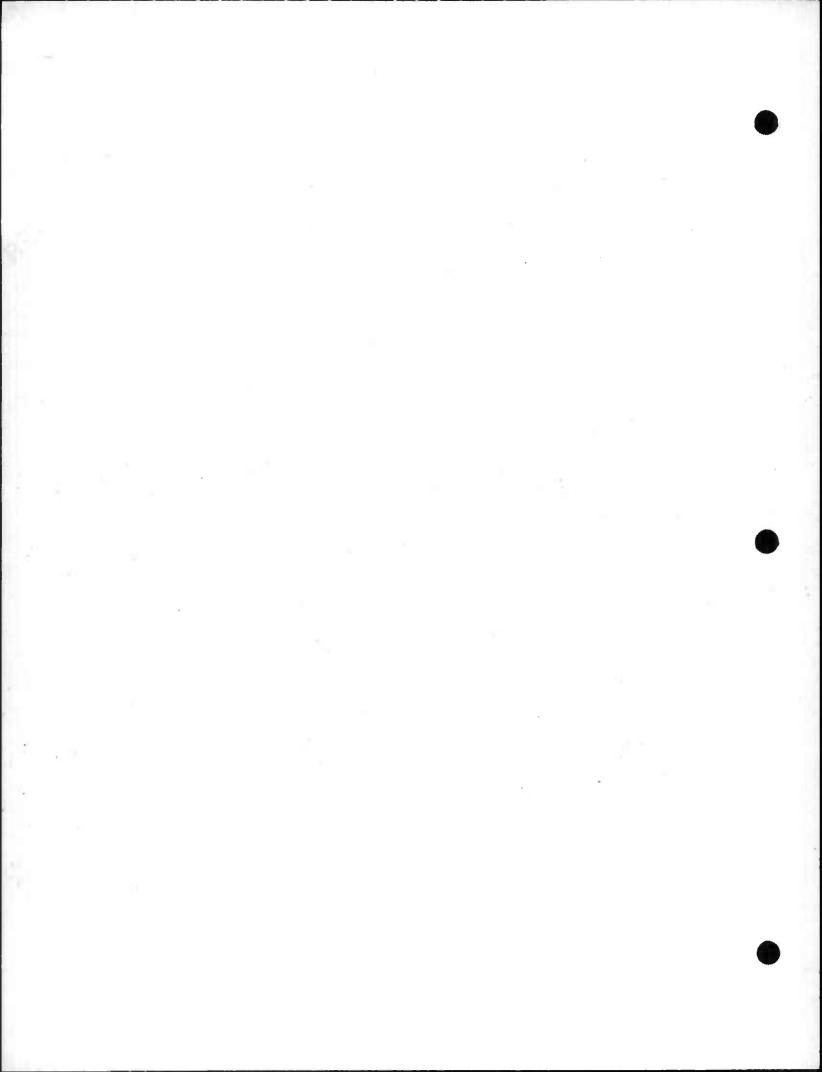
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		t. DECEDENT'S NAME (First, Middle, Last)															
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		4. SOCIAL SECURITY NUMB										Feb.	14.	, 19	995	9:00	a
				5. SEX	6. AGE (In		100	ONTHS D	EAR MYS	IF UNDER	MIN.	7. DATE OF (Month, D	ny. Year)		Country		
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pinous	_	98. FACILITY NAME (If not in:					9	b. CITY, TO				ATH			NTY OF D		
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	2	RESIDENCE OF DEC	10b. COUNTY	,		1	10c. CITY,	TOWN OP	LOCAT	ION					T	10d, INSIDE C	TTV
Pag.	DIRE	Maryland	ltimore						altin	nore					LIMITS?		
5-0020 ending physician. as the burial-transit permit. Pages		10e. STREET AND NUMBER				10f. ZIP CODE							10g. CIT	ZEN OF W	HAT COUNTRY	A	
n. Insit p	FUNERAL	5703 Johnny	Cake	Road		21207					7 US			USA			
Sliciar rial-tra	5	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	NT EVER IN U	J.S. ARME	D					IIC ORIGIN? (Specify Yes or No- 14. R.			14. RACE	- American Ir	ndlan,
5-0020 nding physic is the burial	BY	t Never Married 2 X 3 Widowed 4 Divo									Specify:		n, etc.)		Speck	ly:	
215-0020 attending physician. se as the burial-trar	ED E			CATION	Ta							Minimum				hite_	
C ta s	ETE	(Specify only	highest grade	completed)		(Give i	DENT'S US kind of wor NOT use i	k done duri			g	16b. KII	ND OF BUS	INESS/IND	DUSTRY		
the hospital or detached for u	PE	Elementary/Secondary (0 7th	-12)	College (1-4 or 5			sewif	,				Orm	Home				
AND the hospit detached once.	COMPL	17. FATHER'S NAME (First, MI	iddle, Last)		1	11003	SCMII	.e		ta MOTE	IFR'S NAM	ME (First, Midd					
Z > 8 %	TO BE CC			stin Kli	ine					100		e Mil			17		
MARY retained to 5 should		19a. INFORMANT'S NAME (7)				19b. M	ALLING A	DDRESS (S	itreet a			oute Number,					
BALTIMORE, N hours after death, Page 6 may be re ed in by the funeral director, page 5 or removal. medical examiliner must be ne		Nelson Lero	y Will	ingham,	Sr.)3 Jo					Balti				7	
		20a. METHOD OF DISPOSITI	ON		20b. P	LACE AND	DATEOF	DISPOSITION				DATE	Y		City or Tox		
		1 Donation 5 Other		oval from State	- Met	ery, cremat	cory or other	torv	.]	Inc.	02/	15/95	Bal	timo	re.	MD	
		21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEE Dawn	ı F. M			22. NA	ME AN	D AOORES	SS OF FAC	HLITY					
	;	Haws	14.	Mesola	mal	al						iety				Inc. D 2122	0
		23. PART I. Enter the di	seeses, or o	omplications the	et caused t	ha death	h. Do not	enter th	e mo	de of dyl	ng, such	ss cardied	or respin	ratory sri	reat,	Approxi	imata
		shock, or ha		List only one cau	use on aec	ch iina.											Batween
withing appetent fill cremation, rent, the		disesse or condition resulting in death)	→	AG	nim	à ti	0~	0		o den	imi	-				2	wke
		resulting in daath)	•	DUE TO	OR AS A C	ONSEQUE	ENCE OF	2	1	1	/		~ /	-	7	1	/
	z	Convention, the constal		5	ACA	al	d	icu	bu	Lug	alc	e- '	2/2	ye 1	10	. 3u	-KS
X 8 2º E	CERTIFICATION	Sequentielly list condition if any, leeding to immediately	liete	DUE 10	(OR AS A C	ONSEQUE	ENCE OF):	1	1	L	-4		10				Con
	걸	cause. Enter UNDERLYi CAUSE (Disesse or inju		c. OUE TO	100 AS A C	ONSEQUE	7	7		9	Lu	rely	MAN			12	us
P.O. B. h certificate anding physique pr Hygiene pr or other t	Ē	that initiated events resulting in death) LAS	т	٥٥٤	1/5	O	C OF):	F .	1	6-	W		1			1.7.	100
O = 5 - 0	ä			1. /7	10	LEV	nen	. 77		pe	1/2	nenl	cay			1	1-7
RDS, at the deal by the att and Menta iy Injury,		PART ii. Other algnificat	nt condition	s contributing to	deeth but	not read	ulting in	tha unde	rlying	ceuse g	jiven in F	Part i. 24	n. WAS AN		24b.	WERE AUTOPSY	
DH that	DICAL											_ 1	YES 2	- /		COMPLETION O	
田多言之意	W	/											_	^		1 YES 2] NO
AL RE has been been been been been been been been	ä	DID TOBACCO U	SE CONTI	RIBUTE TO CA	AUSE OF	DEATH	H YES	□ NO		UNC	ERTAIN	1					
The state	5	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	28	. PLACE C	OF OEATH		one)								
F VIT SICIAN: The certificate the State the State to or item	YS.	t TYES 2 NO		t ☐ Inpatiant 2 ☐	ER/Outpsti	lent 3 🗆	DOA 4	Nursing	Hom:	5 Ra	sidence 6	Other (S	pecify)				
OF VITAL R HYSICIAN: The law re his certificate has bee with the State Dept. o	PHYSICIAN:	27. MANNER OF DEATH		28e. OATE OF (Month, D		2	8b. TIME (c. INJ	URY AT		28d. DEŞCR	BE HOW IN	JURY OC	CURED		
	BY		Pending investigation							'ES 2	NO				_		
VISION OF VI ATTENDING PHYSICIAN: ECTOR: After this certifical s after death with the St.	8		Could not be	28a, PLACE C building,	OF INJURY — , etc. (Specify	At home,	, farm, stre	et, factory	office			281. LOCATIO	N (Street a own, State)	nd Number	or Rural A	oute Number,	
DIVISION OR ATTENDING ORECTOR: After hours after death ttem 28 is man	E	11.0000.0	detarmined														
OR / OIRE Hours	MPLET	29a. CERTIFIER (Check only	IFYING PHYSI	CIAN: To the best of	f my knowled	dge, death	occurred	at the time	, date	and placa,	and dua t	to the cause(and man	ner as atal	ted.		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	SO	one) 2 MEDI	CAL EXAMINE	R: On the basis of a	xamination e	end/or Inve	estigstion,	In my opin	lon, d	eath occur	ed at the I	lme, date and	placa, and	due to th	ne cause(s)	and manner e	s stated.
TO I	BE C	296. SIGNATURE AND TITLE	OF GERTIFIE	}			,			290 LICE	NSE NUM	BER		29d, DAT	E SIGNED	(Month, Day, Yei	er)
2 2 2 X		V /	1/	M	1	ph	2017	3h		VD	29	769	- 1	F	ehruz	ary 14,	199
EQ 227	2	30. NAME NO ACORESS OF	PERSON WH	COMPLETEO CAU	SE OF DEAT	(ITEM 2	Type, Pr	rint)						_		**************************************	
		Marcelino A		e, M.D.	516 N	. Ro	llin	g Rd.	S	uite	204	Ba	ltim	ore.	MD :	21228	
		31. DATE FILED (Month, Day,		32. REGISTRA	AR'S SIGNAT	VRE											
		FEB 1 6 19	SUS A	and when	MA TON	i i											

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



1 - FOR STATE REGISTRAR



y the hospital or attending physician. be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

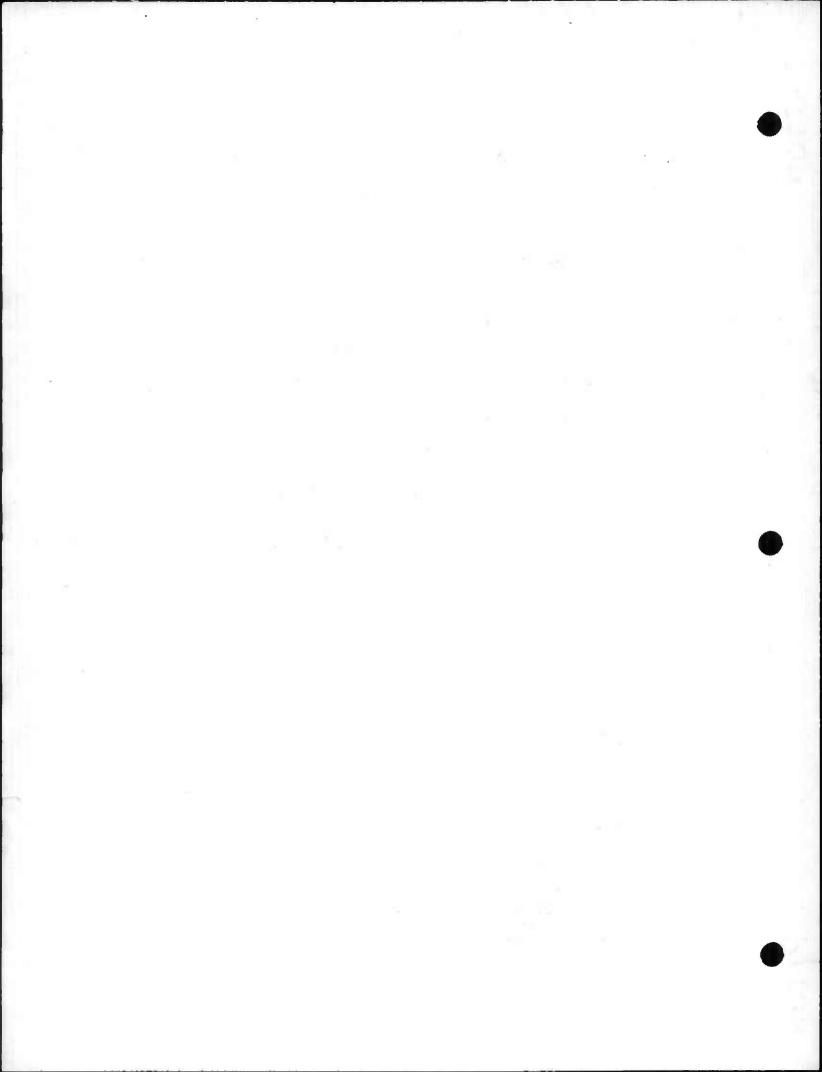
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

				F DEATH	REG. N	0.				
	1. DECEDENT'S NAME (First, Migdle, Last) 1-LORENCE	ZELISSE			2. DATE OF GEATH	PAYOT INE				
	100	8. AGE (In yrs. In:	YRS. IF UNDER 1 YEAR MONTHS DAYS		7. DATE OF BIRTH (Mgnth, Day, Year)	914	IRTHPLACE (State or Fore			
OR	9a. FACILITY NAME (If not institution, give store	et and number)	96. CITY, TOWN	TIMOL	EATH	9c. COUNTY (OF DEATH			
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY, TOWN OR LOC	CATION			10d. INSIDE CITY			
- 1	100. STREET AND NUMBER		DALTI	MOPF 101. ZIP CODE		10g. CITIZEN	1 YES 2 NO			
FUNERAL		2. WAS DECEDENT EVER IN U.S. AF		2/2/3 ECENDENT OF HISPA	NIC ORIGIN? (Specify)	lea or No.— 14. F	ACE - American Indian			
B	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DATES		specify Cuben, Mexic ES 2 P NO Speci	an, Puerto Rican, atc.)		Black, White, atc.			
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co Elementary/Secondap (0-12)	mpleted) (G	CCEDENT'S USUAL OCCUPA live kind of work done during in Do NOT use retired.)	most of working	16b. KIND OF B	USINESS/INDUSTR	ny .			
OMP	17. FATHER'S NAME (First, Middle, Last)		OMEMAKE		OWA	in Sumame)	(E			
BE	19a. INFORMANT'S NAME (Type/Print)	HIFFLETT 10	b. MAILINO ADDRESS (Stree	ROSE and Number or Rural	SHIP Route Number, City or To	FLETT Mr. State, Zip Code	n)			
5	ACTHUR DATAGEL 200. METHOD OF, DISPOSITION	A-TTOR NEY)	5 LiGHT AND DATE OF OIS OSITION (ST.	BALTO DATE 20C. L	MD- 2/	202			
	1 Burlel 2 Cremation 3 Remove 4 Denation 6 Other (Specify)	i from State	The opposite of the opposite o	HORY 2	1498 7	5A-170	Town, State MA			
	Honas .	Skaide	9- SKA	HDA F	# 282	9 HUD	SON ST.			
	23. PART I. Enter the disease or corahock, or heart failure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death)	CERES DUE TO (OR AS A CONSE	Ar TH	RomBo		piratory arreat,	Approximate Interval Bate Onset and I			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury c.									
ERTIFI	that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):									
EDICAL C	PART IN Other algnificent conditions		eaulting in the underlyi	_ 11	PERFO	N AUTOPSY DRMED?	24b. WERE AUTOPSY FINE AVAILABLE PRIOR TO			
Σ	PERIPHERAL	VASCULAR	DISEA	4	LITUS 1 - YES	2 1 100	OF DEATH?			
PHYSICIAN:	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLAC	TH YES NO		N 🗆 📗					
YSIC	1 ☐ YES 2 ☑ NO 1	OSPITAL: Inpatient 2 ER/Outpatient 3		ome 5 - Rasidence	6 Other (Specify)					
ВУ РН	27. MANNED: OF DEATH A. Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	INJURY W	NJURY AT VORK? YES 2 NO	26d. DEŞCRIBE HOW	INJURY OCCURED				
8	3 Suicide 8 Could not be 4 Homicide getarmined 28. PLACE OF INJURY — At home, farm, street, tectory, offica 28t. LOCATION (Street and Number or Rural Route Nul City or Yown, State)									
COMPLET		N: To the best of my knowledge, de On the basis of examination and/or					se(s) and manner se stat			
Ö #		<i>k</i>				_				
H H	ATURE AND TITLE OF CERTIFIER	4	\	29c. LICENSE NUI	WDER	29d, DATE SHOP	NED (Moven, Day, Year)			



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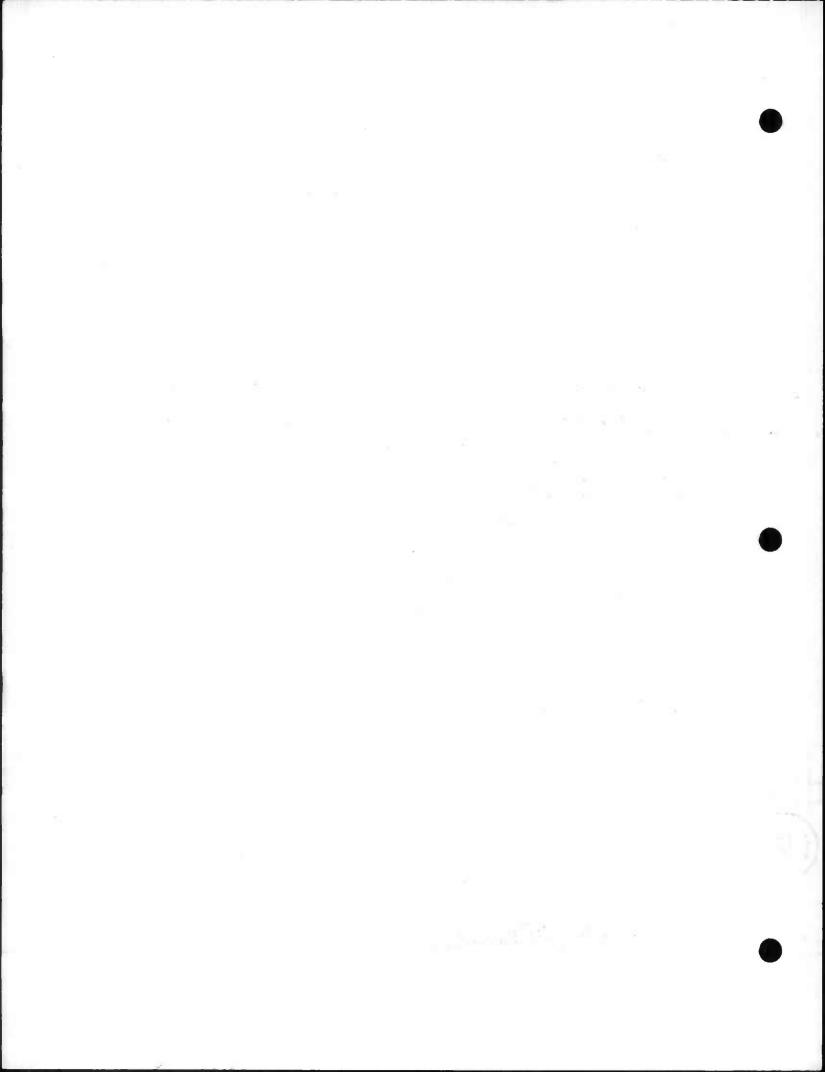
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LINION OF VITAL RECORDS, P.O. BOX 68/60	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hi	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the r
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATN MONTH 3. TIME OF DEATH Betty Rae **ALEXANDER** 1995 рм February 16. 1:15 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTN 8. BIRTHPLACE (State or Foreign 1 □ M 2××× Feb. 8,1934 169-26-6914 YRS. Pennsylvania 61 9a, FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR Franklin Square Hospital Rossville Baltimore County RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Essex 1 YES XX NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 346 Maple Avenue 21221 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2500 IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If ves. specify Cuben, Mexicen, Puerto Rice 1 TYES 2 NO SpecMWhite Specify: BY 3 Widowed 4 Olvorced Œ 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY (Specify only high H Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 11 Assembler Aero Space 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edmond Lejohn BE Myrtle Garnetta 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 William Alexander 346 Maple Ave., Baltimore, Maryland 21221 20e. METNOD OF DISPOSITION

1 X Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION -- City or Town, State HÖÏIŸHïII Mem. Gardens 2/20/95 4 Donetign 5 Other (Specify) Baltimore Co. 21. SIGNATURE OF FUNERAL SERVICE CONSER 22. NAME AND ADDRESS OF FACILITY Bruzdzinski Funeral Home P.A. 1407 Ol&astern Ave.Balt.,MD 21221 23. PART I, Enter the diseases, of comp features that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. only one ceuse on eech line. Intervel Batween IMMEDIATE CAUSE (Final **Onset and Death** diseese or condition e. Multi Organ Failure
DUE TO (OR AS A CONSEQUENCE OF). reaulting in death) 1 day Septic Shock
OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION 3 days Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING c. Malignant Melanoma
oue to (or as a consequence of): CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 KD00 OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 😾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA ng Nome 5 Reeldenca 6 Other (Specify) 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 X Natural м 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, atraet, fectory, office building, etc. (Specify) 3 Suicida 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER (Chack only Chack only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and menner ee stated. (Check only one) 2 MEDICAL EXAMINER: On the basic of examination and/gr investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Monthy Day, Year) us. 2 116 R.D. 1766 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert de la Torre, M.D. 9000 Franklin Square Drive, Baltimore, MD

DNMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buriat, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH ANI	MENTAL HYGIENE
CERTIFICATE OF DEATH	BEG NO

	1 - FOR STATE REGISTRAR			ENT OF HEALTH A		NTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) LERIT Susan	Ek F	ISPL	N		DATE OF DEATH DAY	YEAR	3. TIME OF DEATN		
	4. SOCIAL SECURITY NUMBER 5. SEX 214-23-8490 1 \square M 2	6. AGE (In yrs. iasl	MONTHS DAVE MANNE AND			DATE OF BIRTH (Month, Day, Year) 16-14-1978	8. BIR	TNPLACE (State or Foreign intry) ORTH DAKOTA		
Œ	9a. FACILITY NAME (If not institution, give street and numing 1796 ELBERTA DRIVE	per)	9b.	CITY, TOWN OR LOCATION SEVERN			DEATN			
5	RESIDENCE OF DECEDENT						ANNE	ARUNDEL		
DIRECTOR	MARYLAND ANNE A	RIINDEI.	10c. CITY, TO	NN OR LOCATION SEVERN				10d. INSIDE CITY LIMITS? t YES 2 XNO		
IAL	toe. STREET AND NUMBER	NO IND DB		10f. ZIP CODE			10g. CITIZEN OF	WHAT COUNTRY?		
FUNERAL	7796 ELBERTA DRIVE	CEDENT EVER IN U.S. ARK	- T	21144			U.S.			
B	1X Never Married 2 Married FORCES	CEDENT EVEN IN U.S. ANN I? 1 YES 2 NO GIVE WAR OR DATES	D	13. WAS DECENDENT OF P If yea, specify Cuben, I 1 YES 2 NO	Maxican, Pu	RIGIN? (Specify Yea (lerto Rican, atc.)	Bla	CE — American Indian, ack, White, etc.		
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(GA	e kind of work a	AL OCCUPATION lone during most of working		18b. KIND OF BUSI	NESS/INDUSTRY			
COMPLETED	Elementary/Secondary (0-12) College (1-	4 or 5 +)	Do NOT use retir	Ĺ		HTGH	SCHOOL			
	17. FATHER'S NAME (First, Middle, Lest) DAVID ROGER ASE	LIN			A L	First, Middle, Meiden S INNEA				
TO BE	19a. INFORMANT'S NAME (Type/Print) DAVID R. ASPLIN			RESS (Street and Number or BERTA DRI				1144		
	20a. METNOD OF DISPOSITION 1 Donation 5 Other (Specify)	20b. PLACEA		POSITION (Nama of EMETERY	2	/20	ATION — City or EAPOL			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	6-		1 SECOND	AVE	NUE, S.W	1.	NERAL HOME,		
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ebock, or heart failure. List pnly pne cause pn each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
AL	PART II. Other eignificent conditions contribut	ing to deeth but not re	eulting in the	e underlying ceuee give	en in Pert	i. 24e. WAS AN A PERFORN 1 — YES 2	ED?	4b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO				RTAIN [ב		1 TYES 2 NO		
SIC!	25. WAS CASE REFERRED TO MEDICAL EXAMINER? t YES 2 NO			HER:						
	27, MANNER OF DEATH 1 Natural 5 Pending (M	ATE OF INJURY onth, Day, Year)	28b. TIME OF	28c, INJURY AT WORK?	28d	Other (Specify) I. DESCRIBE HOW IN.	JURY OCCURED			
TED BY	3 Suicide 28e. Pt	ACE OF INJURY — At hon liding, etc. (Specify)	ie, farm, street,	tactory, offica	281.	LOCATION (Street an City or Town, State)	d Number or Rura	I Route Number,		
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the base							v(s) and measur so stated		
BE	356. SIGNATURE AND TITLE OF CERTIFIER	MD		29c. LICENS				ED (Month, Day, Year)		
2	TO NAME AND ADDRESS OF PERSON WHO COMPLETE	CAUSE OF DEATH (ITEM	27) (Type, Print)	WOLFE S	7 6	BACTIMO	RS N	10 5152		
	31. DATE FILED (North, Day, Year) 32. REC 2 \5 \KEB 1 7 1995	Jalia d'audes						in all corre		

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT OF H	IEALTH AND	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)							3. TIME OF OEATH		
	willie F	Tvery				MONTH D	95"	755 A M		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In	n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. B	HRTHPLACE (State or Foreign		
	425-80-0476 9a. FACILITY NAME (If not institution, give stre	49 YRS.	MONTHS DAYS	HOURS MIN.	ssissippi					
DIRECTOR	Mercy Hospital		Baltim		-AIR	9c. COUNTY (
Ē	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCAT	ION			10d, INSIDE CITY		
MD N/A Baltimore								1 X YES 2 NO		
FUNERAL	5302 Bowleys Lane		101	21206		U.S.	OF WHAT COUNTRY?			
5302 Bowleys Lane Apt, E 21206 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Year or No - 14. RACE - America								RACE — American Indian,		
BY F	1 Never Married 2 Marriad 3 Widowed 4 Divorced	FORCES? 1 X YES	Z [] NO TES		ecify Cuban, Maxica 2 NO Specify	n, Puarlo Rican, atc.)		Black, White, afc. Specify:		
	**				**			Black		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co	ompleted)	(Give kind of v	USUAL OCCUPATION work done during mo	ON st of working	166. KIND OF BUS				
٦		College (1-4 or 5+)	life. Do NOT us			Baltimo	re City	Schools		
M	12th 17. FATHER'S NAME (First, Middle, Last)	N/A	Secur	city Off						
						ME (First, Middle, Maiden	Surname)			
BE	James Avery 19a. INFORMANT'S NAME (Type/Print)				Rachel					
2	Denise Rich					Route Number, City or Town Baltimore,				
	20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Remove	20b.1	PLACE AND DATE	F DISPOSITION (Na	me of	OATE 20c. LO	CATION - City	or Town, Stata		
4 Donatton 5 Other (Specify) Garrison Forest Vet 22195 OWINGS IIII							gs mills	, Md		
	• WWW	Dec				Home East Avenue/Ba	ltimore	e, MD 21202		
	23. PART i. Enter the dieeeeea, or cor	polications that ceused	the death. Do r	ot enter the mo	de of dylng, auc	h as cerdiec or respi	ratory arreet,	Approximete		
	ehock, or heert fellure. Life IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Metastati		dder	Cana	cer		Intervei Between Onset and Death		
z	DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF	j:						
FIC	CAUSE (Diseese or Injury thet initieted events	DUE TO (OR AS A	CONSEQUENCE OF	j:						
ERT	resulting in deeth) LAST									
	PART II. Other eignificent conditions	contributing to deeth bu	t not regulting i	n the underlying	course alven in	Part I. 24a. WAS AN	AUTOROV	Att WEST AUTOMOV STATE		
CAL		overlanding to doon bu	t not recording i	ii die dilderlying	cauee given in	PERFOR		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO		
<u>a</u>						1 YES 2	NO	COMPLETION OF CAUSE DF DEATH?		
Σ	DID TOPACCO LIST CONTRI	DUTE TO CAUSE OF	DEATH NO	. C No C				1 YES 2 NO		
AN	DID TOBACCO USE CONTRII		6. PLACE OF DEAT		UNCERTAIN	<u> </u>				
PHYSICIAN: MEDIC	EXAMINER?	HOSPITAL:		OTHER:						
¥	27. MANNER OF DEATH	28a. OATE OF INJURY	28b. TIM			6 Other (Specify) 28d. DESCRIBE HOW II	HIM OCCUPE			
	1 Natural 5 Pending	(Month, Day, Year)	INJ	URY WO	RK? 'ES 2 NO	avo. OESCRIBE NOW II	SONT OCCORE			
AB Q	2 Accident Investigation 3 Suicida 6 Could not be datarmined	28s. PLACE OF INJURY - building, atc. (Specify	– At home, ferm, s	treet, factory, office		281. LOCATION (Street a City or Town, State)	nd Number or Ru	ural Route Number,		
Ë.	0.0500000									
COMPLETED		AN: To the best of my knowled On the basis of examination						ree(a) and manner as stated.		
H H	29b. SIGNATURE AND TITLE OF CERTIFIER				DILL 3			NED (Month, Day, Year)		
임										
	6220 Pitalia 11	A MALE OF DEAL	a Loi	2/00	neen p	1611 MD				
	6320 Pitchie 14 31. DATE FILED (Month, Day, Year)	37 REGISTRAR'S SIGNAT	Suiki	Glen B	urnie	MD 2100	0/			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769

hours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing to THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, III item 28 is marked, or Item 23 shows any Inliury or other teamments.

30. NAME AND ADDRESS OF PERSON

Report Key

31. DATE FILED (Month, Day, Year)

FEB 1 1995

REGISTRAD'S SIGNATURE

	ITEM: 6 per F	.н. G-720 2/17/95 r	eb			95 04937			
	FOR STATE REGISTRAR	STATE OF MARYLAND		T OF HEALTH AND	MENTAL HYGIENE REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Lest)	Lee 1	Allen		2. DATE OF DEATH MONTH DAY	Y YEAR 3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. I	MONTHS	TR 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	B. BIRTHPLACE (State or Foreign Country)			
TOR	90. FACILITY NAME (If not institution, give s GiF+ 0 F /fo RESIDENCE OF DECEDENT	rent and number) 1 e Home	96. CIT	y, town or location of		9c. COUNTY OF DEATH			
DIRECTOR	10e. STATE 10b. COUNT	10d. INSIOE CITY LIMITS? VES 2 NO							
FUNERAL		LIERNE AV	E	3 A / TO	1205	10g. CITIZEN OF WHAT COUNTRY?			
B≺	11. MARITAL STATUS 1 Was DECEDENT EVER IN U.S. ARMED 1 Nover Married 2 Married 3 Wildowed 4 Divorced 1 VES 2 NO 1 VES 2 NO 1 VES 2 NO 1 VES 2 NO 1 VES 2 NO 1 VES 2 NO 1 VES 2 NO Specify:								
PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	completed)	DECEDENT'S USUAL Give kind of work done fe. Do NOT use retired.	during most of working	16b. KIND OF BUSI	INESS/INDUSTRY			
E COMPLET	17. FATHER'S NAME (First, Middle, Last)	2/100	animy		IAME (First, Middle, Meiden S	Surname)			
TO BE	19a. INFORMANT'S NAME (Type/Print) BRend A	Addison	96. MAILING ADDRES	SS (Street and Number or Rura		A - List Colored			
	20a. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	oval from State cemelery	rematory or other place	SITION (Name of	9AJE 20c. LOC	ATION - City or Town, State A/TV · Md			
	Patricia	BILL.		Betts F	uneral uneral	Home 2/2/3 5+ BAITO Md			
	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	s. Prog ve 54	ine Dec		ch as cerdiac or respin	Approximate Interval Between Onset and Death			
NOI	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):								
ERTIFICATION	if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO (OR AS A CONS		oundes	cienty	4 Yeung			
MEDICAL CE	PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Payout to peula 1 yes 2 10 0								
	DID TOBACCO USE CONT		ATH YES			1 TYES 2 M NO			
PHYSICIAN:	EXAMINER? 1 YES 2 90	HOSPITAL: 1 Inpetient 2 ER/Outpetient 28s. DATE OF INJURY	OTHE	R: rsing Home 5 - Residence	6 TOther (Specify) Ho	me yor Homeless ATB			
BY	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) 28e. PLACE OF INJURY — At I	28c. INJURY AT WORK? 1 Yes Z NO	28d. OEŞCRIBE HOW IN.					
LETED	4 Homicide determined	building, atc. (Specify)			City or Town, State)	nd Number or Rural Route Number,			
COMPLETE	(Check only	CIAN: To the best of my knowledge, on the bests of examination and/or				ner as stated. due to the cause(a) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, D 20c. LICENSE NUMBER 29d. DATE SIGNED (Month, D 20c. LICENSE NUMBER 29d. DATE SIGNED (Month, D 20c. LICENSE NUMBER									

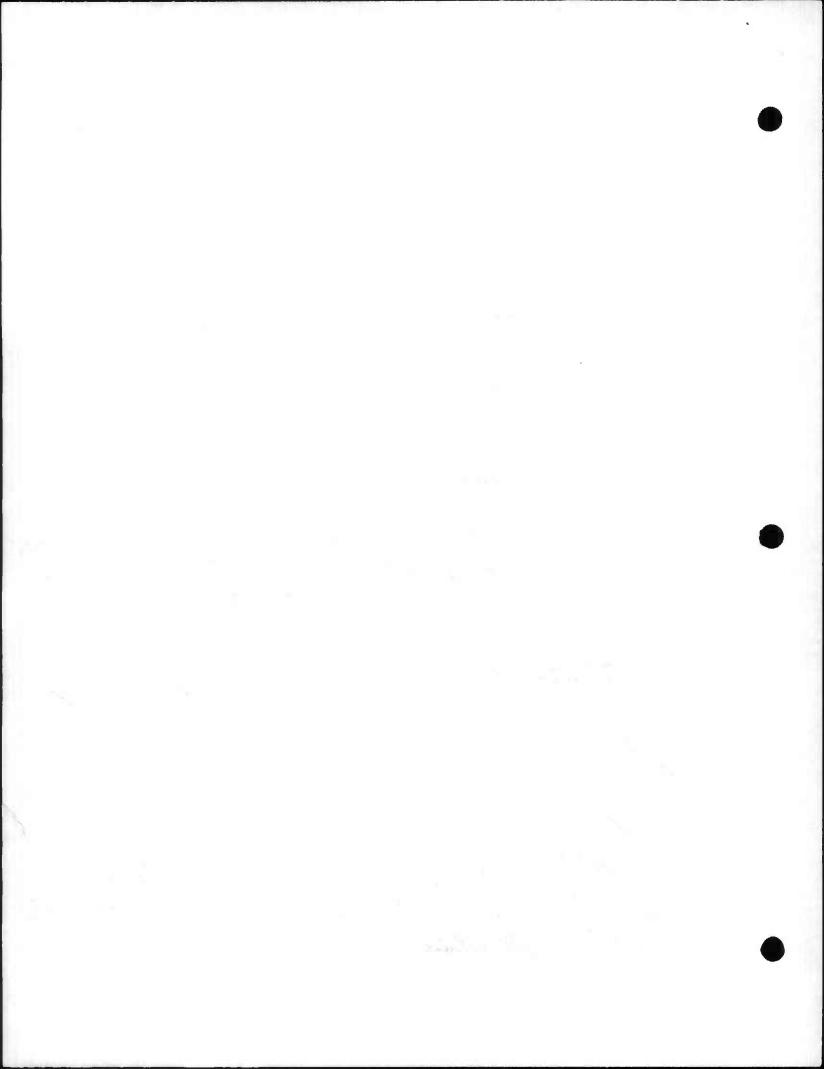
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DIVISION OF VITAL RECORDS,	The second secon
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 300 P . Richard Earl Baker II Feb 14 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 1 🖾 M 2 🗌 F 213-72-1513 38 Aug 6, 1956 Maryland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 5421 Ridge Airy Carroll RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Carroll Mt 1 YES ZE NO Airy permit. FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 5421 Ridge Road 21771 U.S.A. retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE --- American Indian, Black, White, etc. **BALTIMORE, MARYLAND 21215-0020** 1 Never Married 2 Married If yes, specify Cuben, Maxican, Puerto Ricen, etc.) 1 TYES 2 X NO Specify. BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a, DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Maintenance Technician Comcast 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surneme) 76 Richard Earl Baker BE Betty Allender Α. notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Richard Baker 5421 Ridge Road Mt Airy, MD 21771 death. Page 6 may be be 20e, METHOD OF DISPOSITION
1 Burlel 2 🗵 Cremation 3 🗆 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must cemelery, cremetory or other place)
Carroll Cremation Services 2/15 4 Donation 5 Other (Specify) . Hampstead, Maryland examiner 21. SIGNATURE OF PINIERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY enkins Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 in and completely filled in by the to burial, cremation, or removal. within 24 hours after medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or heart fallure. List only one cause on each line. Interval Betwe IMMEDIATE CAUSE (Fine) Onset and Daeth the disease or condition MONIA event, reaulting in death) IMMUNE DEPICIENCY SYNDRUME certificate be executed traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leeding to immediate signed by the attending physician Health and Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF) thet initiated events resulting in death) LAST 9 PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMEO? MEDICAL amy 1 TYES 2 NO OF DEATH? Shows 1 TES 2 NO certificate has been h the State Dept. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DI UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) Hem **EXAMINER?** HOSPITAL: 1 YES 2 NO OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 5 Residence 6 - Other (Specify) 6 27. MANNER OF OEATH 28e. DATE OF INJURY L OR ATTENDING PHYSIC L DIRECTOR: After this ce ! hours after death with ti 26b. TIME OF 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED marked. 1 Natural 1 YES 2 NO BY Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 28 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(s) and menner as stated. THE HOSPITAL OF THE FUNERAL C TO THE HOSPITA
TO THE FUNESA
De filed within 7
IMPORTANT: I stigation, in my opinion, desth occured at the time, date end placs, end due to the ceuse(e) end menner ee stated. 29b. SIGNATU 29d. DATE SIGNED (MONTO) BE 2 ANNAPULIS

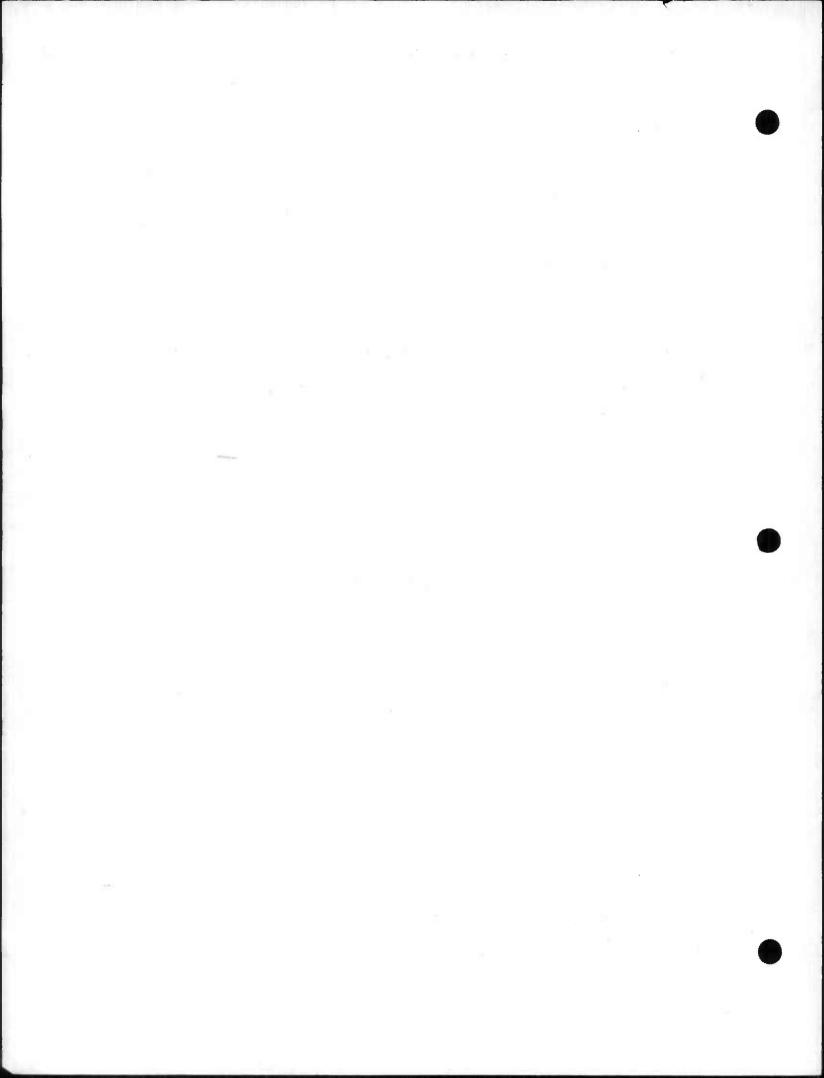


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29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner se stated. 2 MEDICAL EXAMINER: On the beats of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(e) end mer 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, D 2 15/95 30. NAME A 0 ADDRESS OF PERSON WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)	ber,	or Rural Route Numbe	nd Number of						street, fe	nome, farm.	JURY — At (Specify)	e. PLACE OF building, a	be	Could not	3 Suicide 8	
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30. NAME A D ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	Pay, Year)	SIGNEO (Month, Day	29d. DATE		MBER	ENSE NUI	29c. LIC						IFIER	OF CERT	SIGNATURE AND TITLE	
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31. DATE FILED (MONTH), Day, YOAR) FEB 17 1995 Julia Davidson Randall	ME LO	BALTIMOT	6/6 /	2 5 Jane	5 2	me	INE/	EDVL		EUN	F (N'	DEFT	up	Year)	DATE FILED (Month, Day,	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



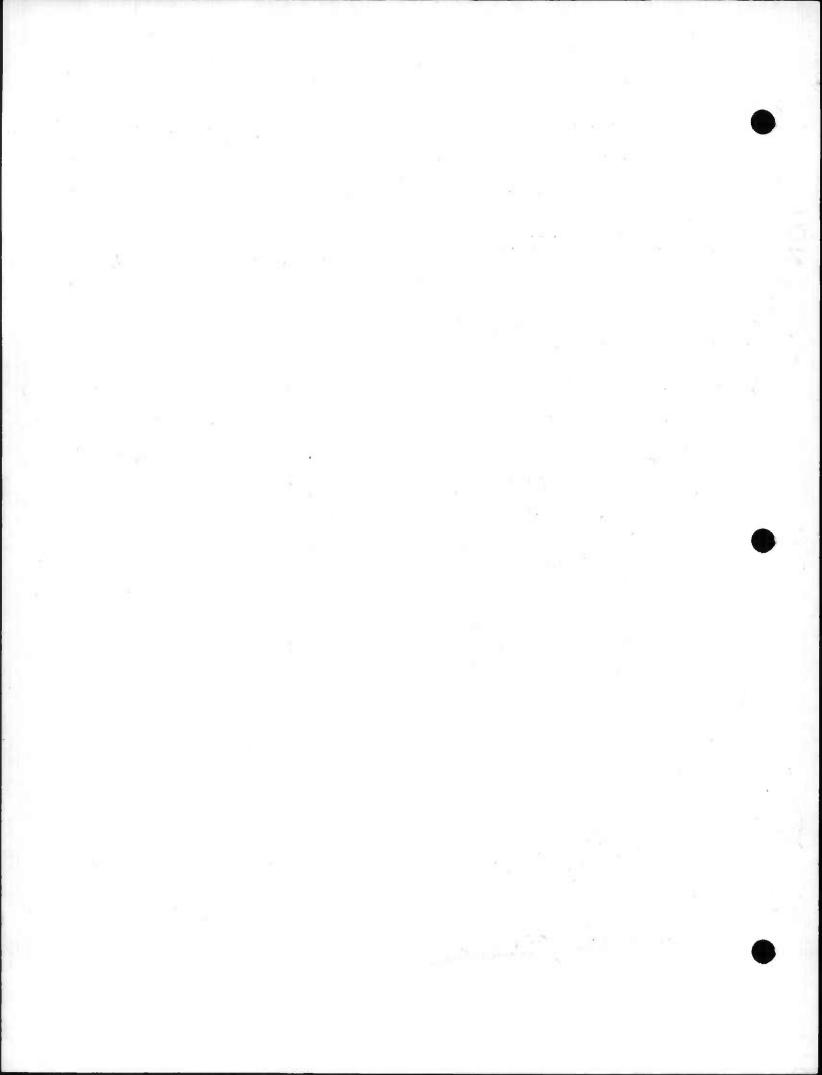
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TO THE PERMIT OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or a	TO THE FURTHER DIFFERING After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us	- be fied . It is the control of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPART	TMENT CATE	OF HE	ALTH AND I		YGIENE EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)		1.5				2. DATE OF C			YEAR 3.T	INE OF BEATH
	Rhea Cather							el B	3,19	15-11	100 "
	4. SOCIAL SECURITY NUMBER		rs. lest birthday) YRS.	IF UNDER 1		FUNDER 14 HRS. OURS MIN.	7. DATE OF 8 (Month, Da	g/Mear)		6. BIRTHPLAC Country)	E (State or Foreign
	216-30-8179 9a. FACILITY NAME (If not institution, give st	0,	Z THS.	Oh CITY	TOWN OF I	LOCATION OF DE	Apri/	4,1		Mary TY OF GEATH	Annual Control of the
NO R	St. Joseph's Hos				lowso		EATH	- 1		Baltim	
اظ	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		I too CITY		WN OR LOCATION						
DIRECTOR		ltimore	Toc. City			4				100	INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	Ittillore		Sp	arks 101. zi	P CODE			10g. CITIZ	EN OF WHAT	YES 2 X NO
FUNERAL	14204 Dove Cree	k Way unit 20)8			21152				USA	
2	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U	S. ARMED	13. W	WAS DECEN	DENT OF HISPAN by Cuben, Mexica	NIC ORIGIN? (S	pecify Yas	or No-		merican Indian,
BY I	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATE				NO Specify		, etc.)		Specify*	White
	15. DECEDENT'S EDUC	CATION 10	ia. DECEDENT'S I	JSUAL OC	CUPATION		16b. KIN	D OF BUSI	NESS/INDU	USTRY	WIIICE
15	(Specify only highest grade Elamentary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of wi	ork done du retired.)	uring most o	of working	100. Kill	0 01 0001	NESS/IND	John	
절		2	Homen	naker				(Own H	lome	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				1	8. MOTHER'S NA	ME (First, Middle				
H H	Leonard J.	Matusky				Gertr			zabet		Rhea
임	19a. INFORMANT'S NAME (Type/Print) James G. Brinsfie	old				Number or Rural F	The state of the state of			,	
	20a. METHOD OF DISPOSITION		ACE AND DATE O				, unit			irks, l	4D 21152
	1 X Burial 2 Cremation 3 Rame 4 Donation 5 Other (Specify)		ry, cremetory or oth aney Va				1 17			, Mar	
	21. SIGNATURE OF FUNERAL SERVICE LIE	SENSEE	aney va	22. N	AME AND	ADDRESS OF FA	CILITY		JIII	Hal.	/ Lanu
	Bryan W. Clary	2. Clary				on Fune				100	01000
	23. PART I. Enter the diseases, or o	complications that caused the	ne desth. Do no	ot enter 1	the mode	Padon	h ss cerdiec	or respire	non1u	m, MD	21093 Approximate
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	disease or condition resulting in death)	. Houb Ill	lelaro	10/	2016	250/1	on			į	
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No I	Sequentially list conditions,	b. DUE TO (OR AS A CO	NEEGHENOT OF								
RTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DOE TO (OR AS A CO	INSECUENCE OF).						i	
음	CAUSE (Disease or injury that initiated events	C. DUE TO (OR AS A CO	INSEQUENCE OF):						1	
ERT	resulting in death) LAST	d									
O	PART II. Other significant condition	e contributing to deeth but	not resulting in	n the und	ieriving c	euse niven in	Part i tás	WAS AN A	UTOPSY	Jan wen	E AUTOPSY FINDINGS
MEDICAL					scriying o	ouse given in		PERFORM	BEO7	AWAI	LABLE PRIOR TO
							_ '	YES 2	NO		DEATH?
							_			'-	YES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMPLER?	HOSPITAL:				E OF DEATH (Ch	eck only one)				
YSI	1 YES 2 NO	1 - Inpatient 2 - ER/Outpatie	ant 3 🗆 DOA	OTHER:		5 🗆 Rasidenca	6 Other (Sp	ecify)		_ <	
T 27. MANNER OF DEATH 26s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED						URED					
B	2 Accident investigation M 1 YES 2 NO										
	3 Suicide 8 Could not be 4 Homicide datarmined	building, atc. (Specify)	At rivine, ferrir, at	neet, motor	ny, onica		City or To	wn, State)	ia number (or Hurai Houte	Number,
LET.	29s. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the heat of my knowled	ne death conum	d at the tim	no dete en	d alone and due	An dha anni ta	and the same	Chelles at		
COMPL		CIAN: To the best of my knowled R: On the basis of examination as									manner as stated.
	296. SIGNATURE AND TITLE OF CERTIFIER					c. LICENSE NUN					th, Day, Year
BE	Marken	10 m	100	Pin) [150	183	- 1	DATE	-/ 1/	25
일	36. NAME AND ADMRESS OF PERSON WHI	D COMPLETED CAMPE OF DEATH	111	est.	4	1-0/	ia		_	17-7	V

29d. DATE SIGNEO (Month, Day, Ye

31. DATE FILED (Month, Day, Year)
FEB 1 7 1995



30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF OEATH Kichard Barbari 12:31 02 75 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. lest birthday) 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS 1 🔀 M 2 🗌 F 492-20-8170 YRS. Oct 5, 1922 Missouri Pages 1, 2, 3 should 9e. FACILITY NAME (If not inatitution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Northwest Hospital Center Randallstown Baltimore County 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Baltimore Co. Pikesville 1 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 101 ZIP CODE use as the burial-transit 901 Templecliff Rd. 21208 USA Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—It yee, specify Cuben, Mexicon, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. **MARYLAND 21215-0020** FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATES 1 Never Merried 2 Merried Specify: BY 1 TYES 2 NO 3 Widowed 4 Divorced WW 2 White COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest gi Auto Industry Elementary/Secondary (0-12) College (1-4 or 5+) funeral director, page 5 should be detached for 4th Grade General Mott Motors Spot Welder once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Ħ Samuel Harrison Barbarick Selma N. Hueber notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Ernestine R. Barbarick 901 Templecliff Rd. Pikesville, MD pe BALTIMORE, 20e. METHOD OF DISPOSITION
1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Ridge Mausoleum 4 Donation 5 Other (Specify) Pikesville, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY after death. Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133 the attending physician and completely filled in by the 1 Mental Hygiene prior to burial, cremation, or removal. medical 23. PARTY. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate hours a shock, or haart fallura. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final **Oneat and Death** the 0 Ae M disease or condition resulting in death) 10-11 executed within event, BOX 68760. DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING OR ATTENDING PHYSICIAN: The law requires that the death certificate be in CAUSE (Disease or Injury other OUE TO (OR AS A CONSEQUENCE OF): P.0. that initiated events resulting in death) LAST 10 Injury, RECORDS, PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS been signed by the PERFORMED? AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 YES 2 NO shows Bladde 1 YES 2 1 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item certificate h EXAMINER? HOSPITAL: 1/ Inpetient 2 ER/Outpetient 3 DOA 4 ☐ Nursing Home 5 ☐ Reeldence 8 ☐ Other (Specify) 10 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, 28d. DESCRIBE HOW INJURY OCCURED this c 1 Natural 5 Pending 1 YES 2 NO В After t 2 Accident Investigation 3 Sulcide 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 28t. LOCATION (Street end Number or Rural Route Number, City or Town, State) 50 8 Could not be DIRECTOR: / COMPLETED 28 FUNERAL DIREC within 72 hours (TANT: If Item 5 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date end place, end due to the cause(e) end manner ee stated. HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, desth occured at the time, date and place, and due to the cause(e) and menner 29b, SIGNATURE AND TITLE OF CERTIFIE THE F 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day Year) BE 4450 0 2

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYGIEN			
1110001	1. DECEDENT'S NAME (First, Middle, Last) MARY	SUSAN		BURK	HART	2. DATE OF DEATH DO EBRUARY	15,1995	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLAN (Month, Day Mar) (Month, Day Mar)							THPLACE (State or Foreign NTV)	
OR	98. FACILITY NAME (If not institution, give str 2413 ARBUTON	TON AVENUE BALTIMORE CITY NONE							
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10d, INSIDE CITY	
		ONE	BAL	TIMORE	CITY			LIMITS? 1 ∑ YES 2 □ NO	
FUNERAL	10e. STREET AND NUMBER			100	ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?	
NE I	2413 ARBUTON A	12. WAS DECEDENT EVER IN	U.S. ARMED		21230 ENDENT OF HISPAI		U.S.A.		
à	1 Never Married Married 3 Wildowed 4 Divorced	FORCES? 1 YES	2 X NO	If yes, sp	ocify Cuban, Mexico 2X NO Specif	Bia	ck, White, atc.		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	(Give kind of wo	ECEDENT'S USUAL OCCUPATION Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY					
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+) NONE	HOMEM A			OFIE	HOME		
NO	17. FATHER'S NAME (First, Middle, Last)		понынд	KEK	16. MOTHER'S NA	AME (First, Middle, Maiden	HOME Sumame)		
H	JAMES MONROE	CABLE			ΕV		TUCKI	ER	
2	19e. INFORMANT'S NAME (Type/Print) WILLIAM H.	BUCKHART				Route Number, City or Tow			
	20s. METHOD OF DISPOSITION	20b.	PLACE AND DATE OF	DISPOSITION /Na	me of	CHELLO	TIMORE, CATION — City or 1	MD. 21230 Town, Stata	
	1 A Burial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	G	LEN HAV	EN ME	MORIAL	PK GL	EN BUR	NIE, MD.	
	21. SIGNATURE OF TUNERAL SERVICE LICE	2/m/h-		1 SE	COND A	ENUE, S.	M. / GPEL		
	23. PART I. Enter the diseases, or co	omplications that caused	tha death. Do no	t entar tha mo	da of dylng, auc	h as cardiac or reapi	ratory arreat,	21061 Approximata	
	ahock, or haart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):								
NOL	Sequentially list conditions, fit any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST OUE TO (OR AS A CONSEQUENCE OF):								
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MEDICAL	PART II. Other aignificent conditions	contributing to death bu	t not resulting in	the underlying	ceuse given in	Part I. 24a. WAS AN PERFOR 1 TYES 2	MED?	b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
2	DID TOBACCO USE CONTR	BUTE TO CAUSE OF	DEATH YES	ПМОП	UNCERTAIL			1 TES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEATH		ONCERTAIN				
YSIC	1 TES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Output		OTHER:	5 Hesidenca	6 Other (Specify)			
	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME INJUI	TY WO	RIC?	28d. DEŞCRIBE HOW II	NJURY OCCURED		
B	2 Accident Investigation	28s. PLACE OF INJURY	- At home, term, str.	M 1 7	ES 2 NO	28f. LOCATION (Street a	and Number or Rural	Pour Mumber	
	4 Homicide 6 Could not be determined	building, atc. (Special	(y)	aut, tuotory, orno		City or Town, State)	ING HUMBOR OF FIGURE	route Number,	
COMPLETED		IAN: To the best of my knowle : On the basis of examination						a) and manner as stated.	
шШ	29b. SIGNATURE AND TITLE OF CERTIFIER	CM	0		29c. LICENSE NUM			D (Month, Day, Year)	
TO B	20 NAME AND ADDRESS OF STREET	1 50	_ \		025	854	1/1	6/95	
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, P	rint)					
ŀ	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA							
	FEB 1 7 1995 S	Win Studier R	A. II						

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Pages 1, 2, 3 should

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending phy	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bu		
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ATTEN	ECTOR	s after	n 28
AL OR	AL DIR	2 hour	If item
10SPIT	UNER	rithin 7	ANT:
THE P	THE F	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH BACKHAUS 1995 MILDRED 05:42 PM FEB 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. leat birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign 1 M 2 F 216-12-2869 11-29-22 Maryland 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR University Hospital Baltimore Harford 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Harford Joppa 1 TES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 401 Philadelphia Road 21085 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. 1 Nover Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 TES 2 NO Specify Specify: B 3 Widowed 4 Divorced White 03 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY (Specify only hig H Elementary/Secondary (0-12) College (1-4 or 6+) COMPL Housewife At Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Joseph M. Loque BE Sadie (unknown) 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Backhaus Joseph E. same as #10a - #10f 20s. METHOD OF DISPOSITION
1A Burlet 2 Cremation 3 Removel from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State cemetery, cremetory or other place)
Parkwood Donation 5 - Other /So 2-18-95 Balto. Co. Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Rd., Baltimore, Md. 21214 26. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart fallure. List only one ceuse on each line. Interval Betw IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in daeth) CHRONIC RENAL FAILURE MONTH DUE TO (OR AS A CONSEQUENCE OF) DIABETES MELLITUS CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24e. WAS AN AUTOPSY PERFORMED? PERIPHERAL VAR CULAR DISEASE 1 | YES 2 | NO OF DEATH? 1 YES 2 THO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: EXAMINER? OTHER: etlant 2 - ER/Outpetlant 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNED OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending investigation 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(a) and manner as stated. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE P44098 FEB 15 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CP HENRY R. ADMMS CONLEY SHOCK TYMMYA CENTER FEB 1 1995 32. REGISTRAR'S SIGNATURE

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		1 - FOR STATE REGISTRAR	STATE OF MARYI		TMENT OF H		MENTAL HYGIE		
		1. DECEOENT'S NAME (First, Middle, Last)					2. DATE OF DEATH WONTH FEB	1 °1 ′ 19′	3. TIME OF DEATH
		RIA BILLET 4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	T a	. BIRTHPLACE (State or Foreign
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s 1, 2,	DIRECTO	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY			1101				
it. Pages	DIRE		TGOMERY		THESDA	ITON			10d. INSIDE CITY LIMITS? 1 YES 2 NO
if permit.	ERAL	10e. STREET AND NUMBER	N.D.			20817			N OF WHAT COUNTRY?
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ay be retained page 5 should be notified	요	DEBORAH BILLET	Γ						, MD 20874
E 2 2		20a. METHOD OF DISPOSITION 1 Burial X Cremetion 3 Remark 4 Donetion 5 Other (Special)		b. PLACE AND DATE of metery, crematory or of		ame of	OATE 20c.	LOCATION — CIT	y or Town, State
BALIIMOR after death. Page 6 m by the funeral director, moval. ical examiner must		21. SIGNATURE OF FUNERAL OCH CE	NOTE .	1	IVES	ND ADDRESS OF FA	CILITY		
- e e		Course &	Melin	or -			BLVD,		
filled in by the on, or remove		23. PART I. Enter the dieeeees, or co shock, or heart fellure. L	ist only one cause on o	ed the deeth. Do r eech line.	ot enter the mo	ode of dying, suc	ch as cerdiac or re-	piratory arrea	t, Approximata Interval Between Onset and Death
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a or air or	ATIO	Sequentielly list conditione, if eny, leeding to immediate cause. Enter UNDERLYING							
D to to to	ERTIFICATION	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF	7):				
the death certificate death certificate attending properties in Mental Hygien injury, or other	CER	resulting in deeth) LAST							
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The law requires that the has been signed by ate Dept. of Health and the same any the same any the same any the same any the same any the same any the same any the same any the same any the same any the same any the same any the same any the same any the same any the same any the same any the same any the same any the same and t	MEDIC	-					1 TYES	2 NO	OF DEATH?
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After this of death with a marked.	ВУ	X Natural 5 Pending 2 Accident Investigation			M 1 🗆	YES 2 NO			
TTEN TOP:	TED	3 Suicide a Could not be 4 Homicide determined	28e. PLACE OF INJUR building, atc. (Spe	T — At nome, farm, s	Rreet, factory, offic	•	28f. LOCATION (Stree City or Town, Sta	it and Number or te)	Rural Route Number,
L OR A DIRECT Pours Hitem	COMPLET		IAN: To the best of my know						
		29b. SIGNATURE AND TITLE OF CERTIFIER	On the basis of examination	on and/or investigatio	n, in my opinion, d	leath occured at the			ceuse(a) and manner as stated.
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	¥	30. NAME AND ADDRESS OF PERSON WHO					->/-		
In		A. H. ROBERTS 31. OATE FILED (Month, Day, Year)	, II CDR	, MC, US	O IN K	-			
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	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last) DONNA	R.	BIVONS		2. F	DATE OF DEATH DO	·11-95	3. TIME OF DEATH	
3	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 1					Coun	HPLACE (State or Foreign Try)		
TOR	90. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center Baltimore RESIDENCE OF DECEDENT 90. CTY, TOWN OR LOCATION OF DEATH Baltimore								
DIRECTOR	10a. STATE 10b. COUNTY MARYLAND			10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	10a STREET AND NUMBER 1013 HERNDON C	OURT		101. ZIP	225		10g. CITIZEN OF WHAT COUNTRY?		
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 XNO	If yea, specify	ENT OF HISPANIC (Cuban, Maxican, P NO Specify:	ORIGIN? (Specify Yea uarto Rican, atc.)			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade) Elementary/Secondary (0-12) 12 YEARS	CATION completed) College (1-4 or 5 +)	(Give kind of work dor	DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY					
BE COM	17. FATHER'S NAME (First, Middle, Last) CHARLES E. BIVO	NS	HOMEMAKE	18.	MOTHER'S NAME (First, Middle, Maiden FERNS			
TO B	194. INFORMANT'S NAME (Type/Print) MR. EDWARD BIVO	NS 650	196. MAILING ADDRE				n, State, Zip Code)	21030 E, MD.	
	20e. METNOD OF DISPOSITION 1	oval from State can	PLACE AND DATE OF DISP elery, competory, of the project REEN MOUN			2-15 BAI	CATION — City of TO		
	MANUS HUNERAL BERNICE LIC	ezunia	0: K	ACZORO	DORESS OF FACILITY WSKI F FFT ST	UNERAL	HOME	1224	
CERTIFICATION	23. PART I. Enter the diseases, or compile ione that caused the death. Do not enter the mode of dying, such as cardiec or reepiratory arrest, shock, or heart feliure. List only one ceuse on each line. IMMEDIATE CAUSE (Finei disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF):							Approximata Interval Between Onset and Death I hour I hour	
AL	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Type 1 ves 2 No								
CIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Chec	k only one)	INCERTAIN [
BY PHYSICIAN: MEDIC	~ ~ ~	HOSPITAL: 1 Vinpatient 2 ER/Outp 28a. DATE OF INJURY (Month, Day, Year)	atient 3 DOA 4 N	28c. INJURY WORK?	AT 284	Other (Specify) 1. DESCRIBE HOW IN	JURY OCCURED		
	3 Suicide 8 Could not be 4 Nomicide 8 Setermined	28e. PLACE OF INJURY building, atc. (Spec	— At home, farm, street, fa	ome, farm, street, factory, office			nd Number or Rural i	Route Number,	
COMPLETED	2 MEDICAL EXAMINER	CIAN: To the best of my knowl	and/or investigation, in my	opinion, death	occured at the time	, date and place, and	due to the cause(s		
TO BE	SIGNATURE AND TITLE OF CERTIFIER	w.		452	H4161	4-20	PFEBLU	(Month, Dey, Year) ARY-11-95 M D 2 1060	
	Miguel Cabr	completed cause of developments	TN (ITEM 27) (Type, Print) - 7871 Ame	ericano	a Circle	103 Ele	nBurnio	MD21060	
	"FEBI "7"1995" AL	REGISTRAR'S SIGNA							

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OA 801 80, BALTIMORE, MARTLAND SIZIS-0020	PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	r this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should have been use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit.	traumatic event, the medical examiner must be notified at once.
Consider the Constant of the C	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

Items#5.15 G-film 720 per F,H 2/17/95 P.C STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Brown (MN-WASHINGTON) George SR. 2 10:15 14 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS 220-03-9247 1 🔀 M 2 🗌 F 84 85 JULY 27. 909 SOUTH CAROLINA 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR VETERAN HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MO Baltimore 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2124 W. BALTIMORE 21223 STREET USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 K Married It yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: BY Specify 3 Widowed 4 Divorced NAVV BLACK ETED. 15. DECEDENT'S EDUCATION 18s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade UNIVOUN Grade College (1-4 or 5+) COMPL TRACTOR TRAILOR DRIVER COMPANY TRYCKING 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname, CLARENCE BROWN ERNESTINE BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 BROWN MARGARET 2124 W. BALTIMORE ST., BALTIMORE, MD. 212 23 20a, METHOD OF DISPOSITION
1 X Burlal 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE RRISON: FOREST CEMETERY 2-21-95 DWINGS MILLS, MD 4 Donation 5 Other (Specify) 21. SIGNATURE OF TUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD.21223 23. PART t. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ahock, or haart fallure. List only one cause on each line Intarval Between IMMEDIATE CAUSE (Final Onset and Daath disease or condition resulting in death) Intection DUE TO (OR AS A CONSEQUENCE OF): Uro Sepsis CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \boxtimes UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER 1 YES 2 NO 1 6% Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Rasidence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide ETED 8 Could not be 4 Homicide 29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(a) and manner as stated. COMPL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) B

MI

32. REGISTRATE SIGNATURE

MANUE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

2/14/95

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STATE	0F	MARYLAND	/ DEPARTMENT	OF I	HEALTH	AND	MENTAL	HYGI	ENE
		C	ERTIFICATE	OF	DEAT	H		REG.	NO.

		1 - FOR STATE REGISTRAR	STATE OF MARYLAND / CEI	PEPARTMENT OF	HEALTH AND F DEATH	AND MENTAL HYGIENE TH REG. NO.							
		1. DECEDENT'S NAME (First, Middle, Last)	BRADLEY		2. DATE OF DEATH MONTH DA	Y YEAR	3. TIME OF DEATH						
		4. SOCIAL SECURITY NUMBER 214-22-2030	5. SEX 6. AGE (In yrs. last b	YRS. MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year) 4-15-1903	8. BIRT	THPLACE (State or Foreign stry) Ga					
2, 3 should	TOR	Sinai HUSpite RESIDENCE OF DECEDENT	eet and number)	Balti	OR LOCATION OF D		9c. COUNTY OF	DEATH					
it. Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY, TOWN OR LOC	CATION			10d. INSIDE CITY LIMITS? 1 YES 2 NO					
n. ansit permit.	FUNERAL	180 / MC Cu	lloh st		10f. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?					
-0020 ling physician. the bunial-transit	BY FUI	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARME FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	if yes,	ECENDENT OF HISPA specify Cuban, Mexico ES 2 NO Specifi	NIC ORIGIN? (Specify Yea an, Puerto Rican, etc.) fy:	or No— 14. RAC Blac Spe	CE - American Indian, ck, White, etc.					
21215-0020 ital or attending physic I for use as the bunal	LETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	completed) (Give	DENT'S USUAL OCCUPATION of work done during roo NOT use retired.)	TION most of working	16b, KIND OF BUS	INESS/INDUSTRY	O, CC					
MARYLAND 2- retained by the hospital o 5 should be detached for notified at once.	COMPLET	17. FATHER'S NAME (First, Middle, Last)		DHESTIC	18. MOTHER'S NA	AME (First, Middle, Maiden S	Surneme)						
MAR retained 1 5 should notified	TO BE	190. INFORMANT'S NAME (TYPO-Print) Cattle Smith	196.1	- 1 1	and Number or Rural	Route Number, City or Town	I, State, Zip Code)	17 17					
ALTIMORE, leath. Page 6 may be funeral director, page xaminer must be		20a, METHOD OF DISPOSITION 11 Burlel 2 Cremetton 3 Remo	20h BLACE AND	DDATE OF DISPOSITION	vame of and	PATE #03,000	CATION — City or T	Town, State					
0 - 0		21. SIGNATURE OF PURERAL SERVICE LICE	March	Man	AND ADDRESS OF FA	vest walas	sh Aue	Battond Battond					
y filled in by tion, or reme		23. PART I. Enter the diseases, or conshock, or heart failure. L. IMMEDIATE CAUSE (Final disease or condition resulting in death)	PREVIOUS DUE TO (OR AS A CONSCOU	1	node of dying, suc	th as cardiec or respir	atory srrest,	Approximate interval Between Onset and Death					
secuted and com o burial, matic ev	TION	Sequentially list conditions, if any, leading to immediate	ASPIRATTO A	V				8D					
P.O. B h certificat anding phy Hygiene p or other	CERTIFICATION	Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
DS, the de: the at Ment	A	PART II. Other aignificent conditions	contributing to deeth but not ree	ulting in the underlyi	ng cause given in	Pert i. 24a. WAS AN A PERFORM	MED?	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
TSION OF VITAL ITENDING PHYSICIAN: The law TOR: After this certificate has tafer death with the State Dept 28 is marked, or liem 23	IN: MEDIC	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF DEATH	YES NO	UNCERTAI			1 YES 2 NO					
	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2	28. PLACE (NOSPITAL: 1 9-inpetient 2 - ER/Outpetient 3 -	OF DEATH (Check only one OTHER: DOA 4 Nursing Ho	ome 5 🗆 Residence	6 Other (Specify)							
	ву Рн	27. MANNER OF DEATH 1	26e. DATE OF INJURY (Month, Day, Year)	INJURY W	YES 2 NO	28d. DEŞCRIBE HOW IN	JURY OCCURED						
	ETED I	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At home building, atc. (Specify)			281. LOCATION (Street or City or Town, State)		Route Number,					
절절었는	COMPL	29c. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the Ilme, data and place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner as stated.											
TO THE HOSPI) TO THE FUNER BE filed within IMPORTANT:	TO BE	296. SIGNATURE ANOTHER OF CHITTENEN	SMO	4524	29c. LICENSE NUI	WBER - E39847	29d. DATE SIGNED	(Month, Day, Year)					
	-	ERIC D. SK	OLVICK	T) (Type, Print) SINAL LY	65PITAL	BA	UT 17	10					
		S1. DATE FILED (Month, Day, Year) FFR 1 7 1995	Jana diwalan hank	4									

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING THE FUNERAL DIRECTOR: An filed within 72 hours after one PORTANT: If Item 28 is me
Pio Die

	1 - FOR STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Lest)	STATE OF	MARTLA	CER	RTIFIC	MENT	OF H	DEA	TH		REG. N			
	ANTTA	ת			מחמו					MON		DAY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	S. SEX	6. AGE (in	yrs. lest bir	BETH	ELA FUNDER 1	YEAR	IF LINDS	R 24 HRS.	FE	OF BIRTH	3 19	295	HPLACE (State or Foreign
	213-16-5755	1 M 2 N F			YRS.	ONTHE	DAYA	HOURS	MIN.	MAR	th, Day, Year)	1913	WASI	I. D.C.
<u>~</u>	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH										DEATH			
18	RESIDENCE OF DECEDENT													
DIRECTOR	100. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND BALTIMORE CITY											10d. INSIDE CITY LIMITS?		
	10s. STREET AND NUMBER										1 X YES 2 NO			
FUNERAL	3330 WILKENS AVENUE 21229													
S	11. MARITAL STATUS	12. WAS DECEDEN	IT EVER IN	U.S. ARMED	0	13. W	S DEC			IIC OBIG	N? (Specify)		JSA.	
	1 Never Merried 2 Merried	FORCES?	YES	2 X NO		14 7	yes, spe	city Cube	on, Mexical Specify	n, Puerto	Rican, atc.)	ea ot Mo—	Blac	E — American Indian, k, White, etc.
BY	3XXWidowed 4 Divorced					"	_ 123	2 Q NO	эрөспу				Spec	ACK
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)		16a. DECED	ENT'S US	UAL OCC	UPATIO	N El of worki	na	16	b. KIND OF B	USINESS/IN		
E	Elementery/Secondery (0-12)	College (1-4 or 5	+)		NOT use n		my mo	or works	'u					
M M				PA	STOR						СН	JRCH		
	17. FATHER'S NAME (First, Middle, Last)									ME (First,	Middle, Melde			
BE	THOMAS	JOHN	ISON	_					ATIE				OLEMA	AN
2	19e. INFORMANT'S NAME (Type/Print)	7.0									ober, City or To			
	REV. L10YD MARCU	15	-1						AD, I	TMO	NIUM,	MD.	21093	3
	1 A Buriel 2 Cremation 3 Rem	oval from State	20b.P	LACE AND	DATE OF E	Placel	ON (Na	ne of		DA	E 20c. L	OCATION —	City or To	wn, Stata
	21. SIGNATURE OF FUNERAL SERVICE LIE	tout (AKI	BUTUS	CEM	_	_				-95 AI	RBUTU	S, MA	RYLAND
	009910-	22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD.21223												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):													
PHYSICIAN: MEDICAL CE	DIABETES MELLITUS PERFORMED? 1 VES 2/NO PERFORMED? 1 VES 2/NO 1 YES 2										WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
CA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			1 =		26. PL/	CE DF D	EATH (Che	ck only o	ne)			
YSI	t 🗆 YES 2 🗙 NO	1 Inpatient 2		lent 3 🗆 🏻	DOA A	THER:	Home	5 🗆 Re	sidence 6	□ Oth	r (Specify)			
	27. MANNER OF DEATH 1 Natural 5 Pending Investigation	26e. DATE OF (Month, D.		28	b. TIME OF		WOR			26d. DE	CRIBE HOW	INJURY OC	CURED	
ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE O building,	F INJURY — etc. (Specify)	At home, t	term, strae	et, factory	, office			28t. LOC	ATION (Street or Town, State	end Number	or Rural R	oute Number,
290. CERTIFIER N CERTIFICATION PRIVACE AND THE														
COMPLETED	CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner ee stated. MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner ea stated.													
BE C	296. SIGNATURE AND TITLE OF CERTIFIER							29c. LICE	NSE NUME	BER	-	29d, DAT	E SIGNED	(Month, Day, Year)
TO B	Surfit & Julio	-						1.	263	295		1 2	-14	-95
	Suff Form 1 2-14-95 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SVRJIT JULICA MJ 821 N. EUTAGI ST. BALTIMINE 21201													
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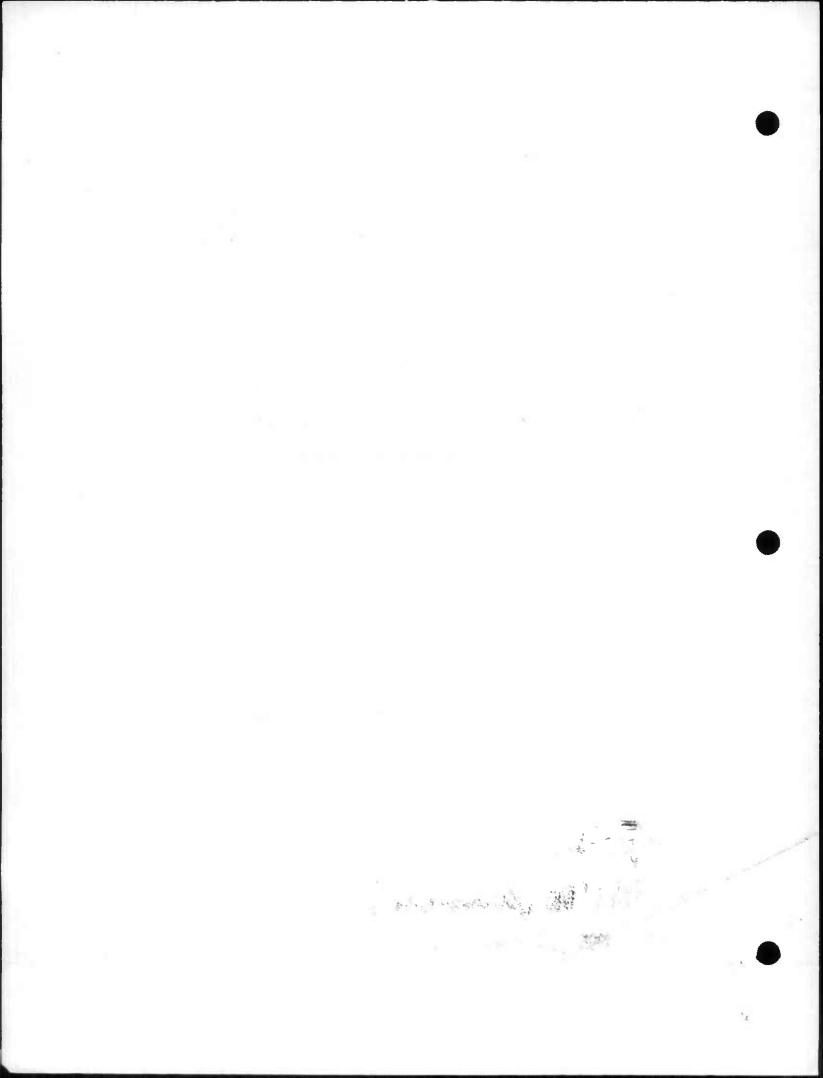
	1 - STATE REGISTRAR	STATE OF MARYI			F HEALTH		NTAL HYGIEN REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last) PAULINE R.	CHEW					DATE OF DEATH DON'TH D		YEAR .	TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 212-18-9379	5. SEX 6. AGE	(In yrs. last birthday		EAR IF UNDER	24 HRS. 7. I	DATE OF BIRTH	CE (State or Foreign				
ec	9a. FACILITY NAME (If not institution, give s	Iniet and number)	01		WN OR LOCATI	ON OF DEATH	1/3/13					
DIRECTOR	Bon Secours Hospital Baltimore											
1 3	Maryland 106, COUNT		10c. C	Balti						LIMITS?		
FUNERAL	100. STREET AND NUMBER 4101 Crawford	Avenue			10f. ZIP CODE 2	21215 Tog. CITIZEN OF WHAT COUNTRY?						
B≺	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I		13. WAS	DECENDENT Cosa, specify Cuba	OF HISPANIC O in, Maxican, Pu Specify:	RIGIN? (Specify Year erto Rican, etc.)	s or No—	Specify:	American Indian, hita, alc.		
PLETED	15. DECEDENT'S EDU (Specity only highest grade Elementery/Secondery (0-12) 12th		16a. DECEDENT' (Give kind o life. Do NOT Class	f work done durii use retired.)	ng most of working					ce		
E COMPLET	17. FATHER'S NAME (First, Middle, Last) Rev. Paul Red	dish					S. Carrolina S. Carolina					
TO B	19a. INFORMANT'S NAME (Type/Print) Geraldine V.	Coe	19b, MAILIN 410	G ADDRESS (SI	reel and Number	or Rural Route Avenu	Number, City or Tow e Bal	n, State, Zip G	Md.	21215		
	20a. METHOD OF DISPOSITION 2 Burlal 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	\bigcirc B	altimo									
	21. SIGNATURE OF FUNERAL SERVICE LIN	CENTEE VI	H	LEB		DYET	T & SO	SON FUNERAL HOME HTS AVENUE @21207				
	23. PAST I. Easer the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, inferval Befwee											
CERTIFICATION	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulfing in daeth) LAST	DUE TO (OR AS	O 1 ONSEQUENCE	D UN				_		V1295		
MEDICAL (PART ii. Othar algnificant condition	s contributing to death	but not reaulting	in the unda	riying cause (givan in Part	PERFOR	RMED?	AVA CON OF	MILABLE PRIOR TO MPLETION OF CAUSE DEATH?		
AN: N	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	OF DEATH Y			ERTAIN [<u> </u>		1	J TES 2 ∐ NO		
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	aldenca 8 🗆	6 ☐ Other (Specify)									
Y PHY	27. MANNED OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. Ti	JURY	:. INJURY AT WORK?		. DESCRIBE HOW I	NJURY OCCU	RED			
TED BY	2 Accident 3 Suicide a Could not be determined	28e. PLACE OF INJUR building, etc. (Spe	Y — At home, ferm,	atreet, fectory,	office	281.	LOCATION (Street a City or Town, State)		Rural Route	Number,		
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated, one) 2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause											
BE CO	296. SIGN TURE AND TITLE OF CERTIFIE	110	pesia or examination and/or investigation, in my opinion, de			death occured at the time, data and place, and due to the ceuse(a) and menner 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day,						
5	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	EATH (ITEM 27) (Typ	e, Print)	100	ハスト	3	1	15	(0)6		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN		CAN	PDI	1mi	110	4121	Kn	1070		
	FEB 1 7 1995	Joli M. J.	Call.							<u> </u>		
	1100 A	•								DHMH-16 Rev 1/89		

DHMH-16 Rev 1/89

STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Curtis MONTH ussell 0820 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. OS (1 M 2 - F DAYS 213-03-3047 Fel 1903 | Maryland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN Randallstown Northwest Hospital Center DIRECTOR Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Maryland Baltimore City 1 2 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 21212 United States use as the burial-transit 846 Reverdy Road Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. **MARYLAND 21215-0020** FORCES? 1 YES 2 NO 1 Never Merried 2 Married Specify: White ВУ 1 YES 2X NO Specify: 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe for Elementary/Secondary (0-12) M.T.A. funeral director, page 5 should be detached 8th grade Driver once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Melden Surname) Cora Mae Bond notified at George Curtis 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stets, Zip Code) 2 5019 Old Court Road Randallstown, MD 21133 Patricia Kovalevski pe BALTIMORE, 20s. METHOD OF DISPOSITION
1 N Buriel 2 Cregation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Druid Ridge Cemetery 2/18 Pikesville, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY death. Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 etmer 7 Reun and completely filled in by the burial, cremation, or removal. medical 23. PART I. Entay the diseases, or complications that caused the days. Do not enter the mode of dying, such as cardiac or respiratory strest, Approximate shock, or heart failure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Death the executed within 24 disease or condition resulting in death) 3-4 wks tallure Keral traumatic event, DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): P.O. BOX if any, laading to immediata the death certificate be cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated eventa other t OUE TO (OR AS A CONSEQUENCE OF): attending resulting in death) LAST 0 signed by the atter Injury, DIVISION OF VITAL RECORDS. PART II. Other aignificant conditions contributing to death but not reaulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1/0 endocarditis CVA with Left hemiparests any 1 YES 2 NO . OR ATTENDING PHYSICIAN: The law requires I DIRECTOR: After this certificate has been signe hours after death with the State Dept. of Health shows Libralation, CHF 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO M UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) this certificate h Item HOSPITAL: OTHER: 1 | YES 2 | NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Nome 5 - Residence 8 - Other (Specify) 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, OEŞCRIBE HOW INJURY OCCURED is marked, 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street end Number or Rurel Route Number, City or Town, Stete) COMPLETED 6 Could not be 28 4 Nomicide item CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. HOSPITAL O FUNERAL D within 72 ho = 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Dlogge MD D35844 1995 0 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D. Roquen Northwest Hosp. Center 5401 Old Court Rd mo 21133 92. REGISTRAR'S SIGNATURE 31. DATE PILED (Month, Day

March March March 1981

		1 - STATE STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.
		1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH
-		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) FUNDER 1 YEAR MONTHS DAYS HOURS MIN. 7. DATE OF BIRTH (Month, Day, Year) Country) 8. BIRTHPLACE (State or Foreign Country) V.A.
2, 3 should	OR	90. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 6AKREFT 6AKREFT
Pages 1.	DIRECTOR	THE STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS?
sit permit.	FUNERAL (100. STREET AND NUMBER 101. ZIP CODE 101. ZIP CODE 102. CITIZEN OF WHAT COUNTRY? 2547 KIRK AVE 2547 KIRK AVE
5-0020 Inding physician. as the burial-transit		11. MARITAL STATUS 12. WAS OECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO If yes, specify Cuben, Mexican, Puerto Ricen, etc.) 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 15. WAS OECEDENT EYER IN U.S. ARMED If yes, specify Cuben, Mexican, Puerto Ricen, etc.)
2 af 8	TED BY	15. DECEDENT'S EDUCATION (Specify only flighest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working
ND 2- hospital o ached for	COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+) III. Do NOT use refired.) LITERIA MOTHER'S NAME (First, Middle, Last) 17. FATHER'S NAME (First, Middle, Last)
8 & & &	BE	17. FATHER'S NAME (First, Middle, Last) (M M et) (M M et) (M M et) (M M et) (M M et) (M M et) (M M et) (M M et) (M M et) (M M et) (M M et) (M M et) (M M et) (M M et) (M m et) (M
F, N y be re sage 5	2	MARLY WIKERS 200. METHOD OF DISPOSITION 200. PLACE AND CATE OF DISPOSITION IN DATE 200. LOCATION — City or Town, State
G 6 6 6		Source 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Source Description of Charles Construct Construction of Charles
BALTIN after death. Pag by the funeral di moval. cal examiner		23. PART I. Enter the diseases, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or reapiratory arrest, Approximate
y filled in by the tition, or remove the medical		ahock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Fine) disease or condition
760 ed withir completel al, crema		a. pnuemonia DUE TO (OR AS A CONSEQUENCE OF): ORDANA CONSEQUENCE OF):
SOX 68 te be execut sician and c prior to burit traumatic	CATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING b. emphysema DUE TO (OR AS A CONSEQUENCE OF): insulin dependent dichetes
P.O. E	ERTIFI	CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST c. insulin dependent diabetes years d.
ORDS, that the dear ed by the att th and Menta any Injury,	CAL C	PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. diabetic nephropathy, neuropathy, retinopathy, gastric- 1 Yes 2 No
REC requires en sign of Healf	: MEDIC	paresis; chronic alcoholism, pancreatitis DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO
TAL The law the has ate Dep	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1
PHYSICI this cer with th	ву РНУ	27. MANNER OF DEATH 1 Netural 5 Pending (Month, Day, Year) 28e. DATE OF INJURY (Month, Day, Year) 29b. TIME OF INJURY AT WORK? 1 YES 2 NO
TTENDII TTENDII affer de 28 is		3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, Stete)
로 되었는	COMPLETE	29e. CERTIFIER (Check only one) 2 IMEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
TO THE HOSPIT TO THE FUNERA DE filed within 7 IMPORTANT: (B	296. SIGNATURA WITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 2712/95
<u>-</u>	5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margaret Kaiser, M.D. P.O. Box 486 Oakland, Md 21550
l e		FEB 1 7 1935 Julia Stevelian-Randell



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TOW OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TOWNS THE CHOIR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

If them 28 is marked, or flem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

D THE DE MEN

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

- 1	1. DECEDENT'S NAME (First	, Middle, Last)							2. DATE OF				3. TIME OF DEATH
		Nan	CV	De	onofr	io			Feb	15	AY 1	995	11:55PM M
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. I		_	R 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTH	,		PLACE (State or Foreign
	212-36-1795		1 🗌 M 2 💢 F	62	YRS.	MONTHS	DAYS	HOURS MIN.	Mar 1	9, 19	32	Countr	
	9e. FACILITY NAME (If not in	stitution, give s	treet end number)			9b. CIT	Y, TOWN	OR LOCATION OF E			_	JNTY OF D	EATH
DIRECTOR	7 Brooklan	nd Rid	ge Road				Luth	nerville			В	alti	nore
H.	10a. STATE	10b. COUNTY	1		10c. CIT	Y, TOWN	OR LOCA	TION					10d, INSIDE CITY LIMITS?
<u></u>	MD	Balti	more		Lu	ther	vil:	le					t TYES 2 TO NO
¥	10e. STREET AND NUMBER						10	H. ZIP CODE			10g. CI	TIZEN OF W	HAT COUNTRY?
FUNERAL	7 Brooklan	d Ridg						21093				JSA	
5	11. MARITAL STATUS 1 Never Married 2 X	Merried	12. WAS DECEOEN FORCES? 1	YES 2 X	RMEO NO	13.	If yes, s	CENDENT OF HISPA pecify Cuben, Mexic	NIC ORIGIN? (Specify Yea	or No-	14. RACE Black	— American Indian, , White, etc.
BY	3 Widowed 4 Divo		IF YES, GIVE V	WAR OR DATES			1 YE	S 2 X NO Spec	ity:			Specia	hite
입	15. DEC	EDENT'S EDU	CATION	16a, E	ECEDENT'S	USUAL C	OCCUPATI	ON	16b, Ki	ND OF BU	SINESS/IN		
COMPLETED	Elementary/Secondary (0	y highest grade 1-12)	College (1-4 or 5	- 6	Give kind of a fe. Do NOT us	work done se retired.)	during m	ost of working					
MP.	12		4	Но	memak	er			Н	ome			
Ö	17. FATHER'S NAME (First, M	iddle, Last)						18. MOTHER'S N	AME (First, Mid	de, Maiden	Surname)		
H	E. Miller R		son					Mar	y Myer	s_			
6	19e. INFORMANT'S NAME (7		_					end Number or Rura					
-1	H. Charles		io, Jr.					Lane, G	len Ar	m, MI	210)57	
	1 - Burial 2 X Crematic	n 3 I Rem	ovel from State		ro Cr			ame of	OATE	1		- City or To	
- 1	4 □ Donation 5 □ Other 21. SIGNATURE OF FUNERA		ENSEE	A Jose C	ro Cr	_		ND AGORESS OF F	ACH ITY	1	aton	ISV11	le, Maryland
- 1	N.	P	yang	La	7	1"		mon Fune		ome			
_	Bryan V		M.A.		/		10	W. Pador	nia Roa	ad, I	imon	ium,	MD 21093
	23. PART i. Enter the di shock, or he	isesses, or c sart fellure.	complications the List only one cau	it ceused the cuse on each lin	ieáth. Do r ie.	not ente	r the mo	ode of dying, su	ch ss cardle	or respi	ratory a	rrest,	Approximate interval Batween
	iMMEDIATE CAUSE (Findisesse or condition	nei	0 0	, (2	, ,	1	~						Onset and Death
ļ	resulting in death)	→		L CA			LC / L						8 HOS.
_			DUE 10	(OR AS A CONS	ECUENCE O	F):							
o o	Sequentially list conditi		b. OUE TO	(OR AS A CONS	EQUENCE OF	P:							
SAT	if any, leeding to immediate. Enter UNDERLY	NG											
CERTIFICATION	CAUSE (Diseese or injuthat initieted events		DUE TO	(OR AS A CONSI	EOUENCE O	F):							
	resulting in death) LAS	' L	d							. =			
	PART II. Other significs	nt condition	s contributing to	death but not	resulting	in the u	nderivin	g cause given in	Part I. 24	a. WAS AN	AUTOPSY	24b	WERE AUTOPSY FINDINGS
୪	HYPERC									PERFOR			MAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL									_ '	YES 2	KNO		DF DEATH? 1 YES 2 NO
- 11	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF DE	ATH YE	sΠ	NO F	LINCERTAL	N M				1 1ES 2 NO
₹	25. WAS CASE REFERRED TO EXAMINER?				CE OF OEAT				17 100		_		
PHYSICIAN:	1 YES 2 KNO		HOSPITAL:	ER/Outpatient	3 DOA	OTHE		ne 5 🂢 Residence	6 Other (S	pecify)			
둔	27. MANNER OF DEATH		28e. OATE OF (Month, D		28b. TIM		28c. IN.	JURY AT	28d. DESCR		NJURY OC	CURED	
<u>B</u>		Pending Investigation				М		YES 2 NO					
		Could not be	28e. PLACE 0 building,	F INJURY — At P etc. (Specify)	nome, farm, s	street, fac	ctory, offic	ca .		ON (Street (lown, State)		or Aural A	oute Number,
		oetermined	<u> </u>										
COMPLETED			CIAN: To the best of										
္ဂ် 📗	2 MEOI	CAL EXAMINE	R: On the beels of e	xemination and/o	r investigatio	n, In my	opinion, o	death occured at the	e time, deta an	d place, en	d due to t	he cause(e)	end manner ae stated.
H	296. SIGNATURE AND TITLE	OF CERTIFIER	}					29c. LICENSE NU	MBER		29d. DA	TE SIGNED	(Montyl, Day, Year)
2	91	Col						0277	30		•	2/16	0/91-
_	30. NAME AND ADDRESS OF												
	Gary I. Co			565 N. (Charle	es S	t.	suite 20)5, Tov	son,	MD	2120)4
	FEB 1 7 19		22. REGISTRA	R'S SIGNATURE									
	LEDT 113	33 A	W WWW	Dr. A. B. A. C.									
													DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

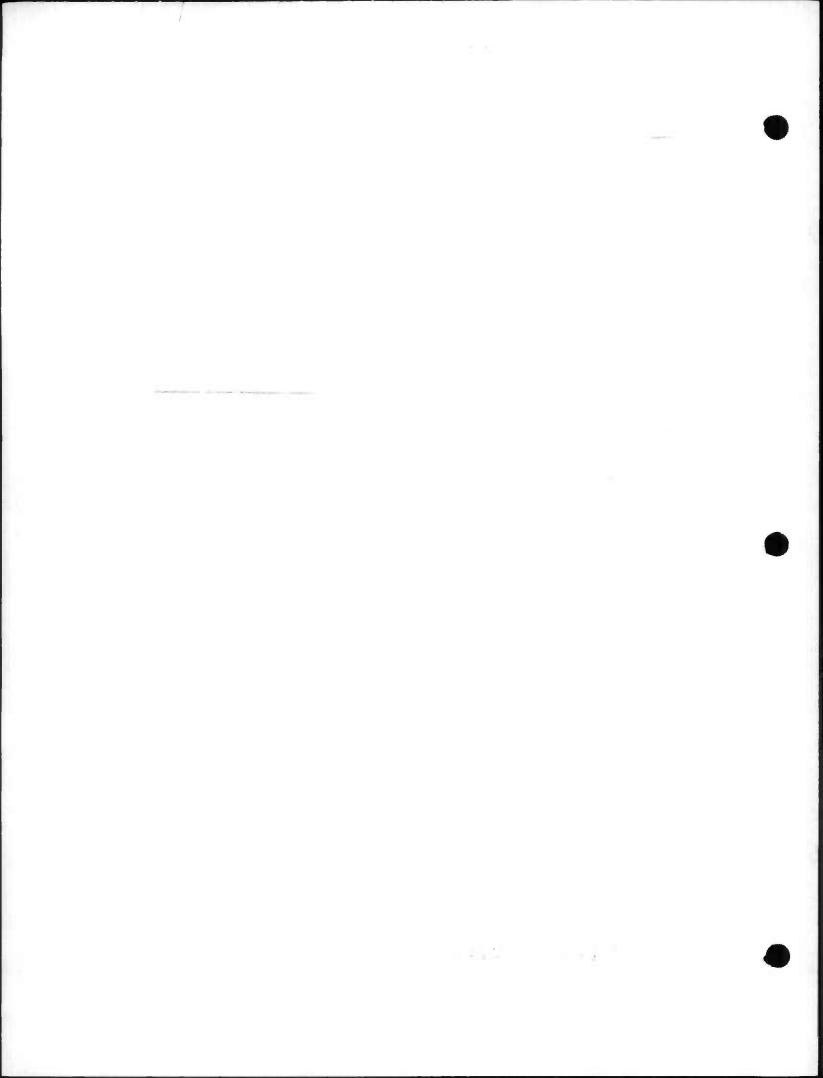
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYGIENE
_	REGISTRAR	CERTIFICATE OF DEATH	REG. NO.
1.	DECEDENT'S NAME (First Middle Leet)		

	REGISTRAR		CERI	IFICA	HE O	F DEATH	F	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Las	1)				 	2. DATE OF				3. TIME OF DEATH
	ch CHARLES ED	WARD DAWSON	J				MONTH	D/		YEAR	
Į.	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last birthe	dmd = ==	NDER 1 YEAR	IF UNDER 24 HRS.	FEBRU		12,1		02:30A M
	215-24-7386	1 🕅 M 2 🗆 F		MONT			OCT.	by, Year)		Count	TO., MD
		2.5	00 "			322		3,19	26	BAL	TO.,MD
	9e. FACILITY NAME (If not institution, giv			9b.		OR LOCATION OF DE	EATH		1 1 1 1 1 1	JNTY OF E	
DIRECTOR	ATLANTIC GENERAL	HOSPITAL			BERL	IN			WC	RCES	TER
5	RESIDENCE OF DECEDENT										
#	10e. STATE 10b. COUI		10c.		WN OR LOC						10d. INSIDE CITY LIMITS?
	MARYLAND BAL	TIMORE]	BALTI	MORE					1 YES 2 NO
4	100. STREET AND NUMBER					IOF, ZIP CODE			10a, CIT	IZEN OF	WHAT COUNTRY?
2	527 FOREST LANE					21228			-	S.A.	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT E	WED IN U.C. ADMICO		45 100 6		na del unio in				
	1 Never Married 2 Merried	FORCES? 1	YES 2 NO	ĺ		ECENDENT OF HISPAN Specify Cuban, Mexica			or No—		E — Americen Indien, k, White, atc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR	W II		1 🗌 Y	S 2 NO Specify	y:			Spec	
										1	WHITE
2	15. DECEDENT'S El (Specify only highest gra		16e. DECEDEI (Give kind	d of work o	one during i	TION nost of working	16b. KIR	ID OF BUS	INESS/IN	DUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)		OT use retir							
8	12TH GRADE		DRAF'	TSMA	N			KELC	0		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	· ·				18. MOTHER'S NA	MEBERTHA	CARO	LINE	ELIZA	BETH KOSLOWSKI
	CHARLES L. DAWSO	N				RUTH MA	RIE WI	LUMA	LLK		
8	19a. INFORMANT'S NAME (Type/Print)		10h MAII	LING ADD	DEEC /0	end Number or Rural I					
2	MR. MARK E. DAWS	ON	527	FOR1	EST I	ANE - BAL	TTMORF	Thy or Town	1, State, Zi	p Code)	
.		ON .	321	TOR	201 1	THILD DITT	II IIIOKI	j III	212	-20	
	20e, METHOD OF DISPOSITION 1 Suriel 2 Cremation 3 Re	moval from State	20b. PLACE AND D	ATE OF DIS	POSITION	Name of	DATE	20c. LO	CATION -	City or To	own, State
	4 Donation 5 Other (Specify)	moral from State	LOUDON .	PARK	CEME	TERY	2/16	BA	LTIM	ORE	
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE /			22. NAME	AND ADDRESS OF FA	CILITY				
	▶ Cackie	10 160	6]]	HUBBA	RD FUNERA	L HOME	E, IN	IC.		
		70- 70- 700	www	_	4107	WILKENS A	VENUE-	BALT	IMOR	RE, M	D 21229
	23. PART I Entar the disesses, D	r complications that c	sused the death. I	Do not e	ntar tha m	oda of dying, suc	h ss cardiac	or respir	retory ar	rest,	Approximate
	iMMEDIATE CAUSE (Final	e. List Dnly Dna cause									Intarval Between Onset and Death
- 1	disease or condition	s. MUD UZ			E.	+					1.
	resulting in death)	· myour	10101	1~	16.00	11100					1 week
1		ODE 10 (OF	AS A CONSEQUENC	E OF):							1
Z	Sequentially list conditions,	b									
CERTIFICATION	if any, laading to immediate	DUE TO (OF	R AS A CONSEQUENC	E OF):							
ঠ ∥	cause. Entar UNDERLYING CAUSE (Disease or Injury	C									
區	that initiated events	DUE TO (OF	AS A CONSEQUENC	E OF):							
	resulting in death) LAST	4.									
8 1		g									+
اب	PART II. Other significant conditi	ona contributing to da	ath but not resulti	ing in the	undariyi	ng cause given in	Part i. 24e	. WAS AN		24b	. WERE AUTOPSY FINDINGS
<u>ა</u>								PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
EDICAL							_ 10	YES 2	□ NO		OF DEATH?
₹											1 TYES 2 NO
ž I											
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26.	PLACE DF DEATH (Che	ick only one)				
S	1 YES 2 NO	HOSPITAL:	R/Outpatient 3 DO		IER:	me 5 🗆 Residence	# [] Other (De				
<u></u>	27. MANNER OF DEATH	26e. DATE OF INJ		TIME OF	_	JURY AT	28d. DESCRIE		IIIIIV OO	CUPED	
	1 Natural 5 Pending	(Month, Day,		INJURY	W	ORK?	280. DESCRIE	SE HOW IN	JUNT UC	COMED	
`	2 Accident Investigation					YES 2 NO					
	3 Suicide 6 Could not b	28e. PLACE OF IN building, etc.	IJURY — At home, fer . (Specify)	rm, street,	fectory, off	ce	261. LOCATIO	N (Street al	nd Number	r or Rural F	Route Number,
COMPLETED	4 Homicide determined						J., J. 10	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
٣ ا	29a, CERTIFIER	CICIAN. To the heat of	hand a second								
윷║		SICIAN: To the best of my									
ğ II	2 MEDICAL EXAMI	NER: On the beele of exam	ination end/or investig	gation, in i	ny opinion,	death occured at the	Ilme, date end	place, and	due 10 11	he cause(s) end manner ee stated.
W I	29b. SIGNATURE AND TITLE OF CERTIF	EA)				29c. LICENSE NUM	IBER		29d. DAT	E SIGNED	(Month, Day, Year)
m	ANL It	1-/1-				144428	_		•	2/12	100
일	30. NAME AND ADDRESS OF PERSON V	HO COMPLETED CAUSE	DE DEATH ATEM 27 /	Time Driver		11 7 00		1		×/15	(7)
	DR. ROBERT J. DI				DTUE	_ סביתו דאי	MADV	T A ATT	0.1	011	/
				VAI L	KIVE	- DEKLIN	, MAKY	LAND	Z1	811	
	31. DATE FILED (Month, Dey, Year)	OID 32. REDISTRAR'S	SIGNATURE								
	FEB 1 7 19	95 Julia	welcor Rardy	4							





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fille	ion,	3
ompletely	filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	PORTANT if item 28 is marked or item 23 shows any injury or other traumosts event the medical annual and an injury or other traumosts event the marked or item.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH MONTH 2 Daniel F. Dugan, Jr. 1995 3:10 p M 5. SEX 6. AGE (In yrs. last birthday) IF UNDER t YEAR IF UNDER 24 HRS. 7. OATE OF BIRTH 9. BIRTHPLACE (State or Foreign DAYS 1 XM 2 - F 165-09-5656 76 YRS 6-22-1918 Pennsylvania 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF OEATH 9c. COUNTY OF CEATH DIRECTOR Long View Nursing Home Manchester Carroll RESIDENCE OF DECEDENT 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Harford Maryland Joppa 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOF 10g. CITIZEN OF WHAT COUNTRY? 1606 Clayton Rd. 21085 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 12 YES 2 NO IF YES, GIVE WAR OR DATES 1941-1945 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EOUCATION (Specify only highest grade complete 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 8 Carpenter Union 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ Daniel F. Dugan, Sr. BE Elizabeth notified a 19s. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Harry Dugan 3815 Water Tank Rd. Manchester, MD. 21102 9 20a. METHOD OF DISPOSITION
1 □ Burisi 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION -- City or Town, State Metro Crematory or other place) 2-18-1995 Baltimore, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Garth Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, MD. 21102 23. PART I. Enter the disasses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, Approximats shock, or heart fellure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onget and Death disesse or condition resulting in desth) OUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): resulting in dasth) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 YES 2 1 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? ck only one HOSPITAL: 1 | YES 2 1 Inpetient 2 ER/Outpetient 3 IDOA **Nursing Home** 8 Other (Specify) 28s. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK?
1 YES 2 NO 28b. TIME OF INJURY 28d. OEŞCRIBE HOW INJURY OCCUREO 1 Natural BY Accident 28s. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify) 3 Suicide ETED 8 Could not be 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide COMPL 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINEF: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and 29b. SIGNATURE AND TITLE OF CERTIFIER BE to bood 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Pri 14

223

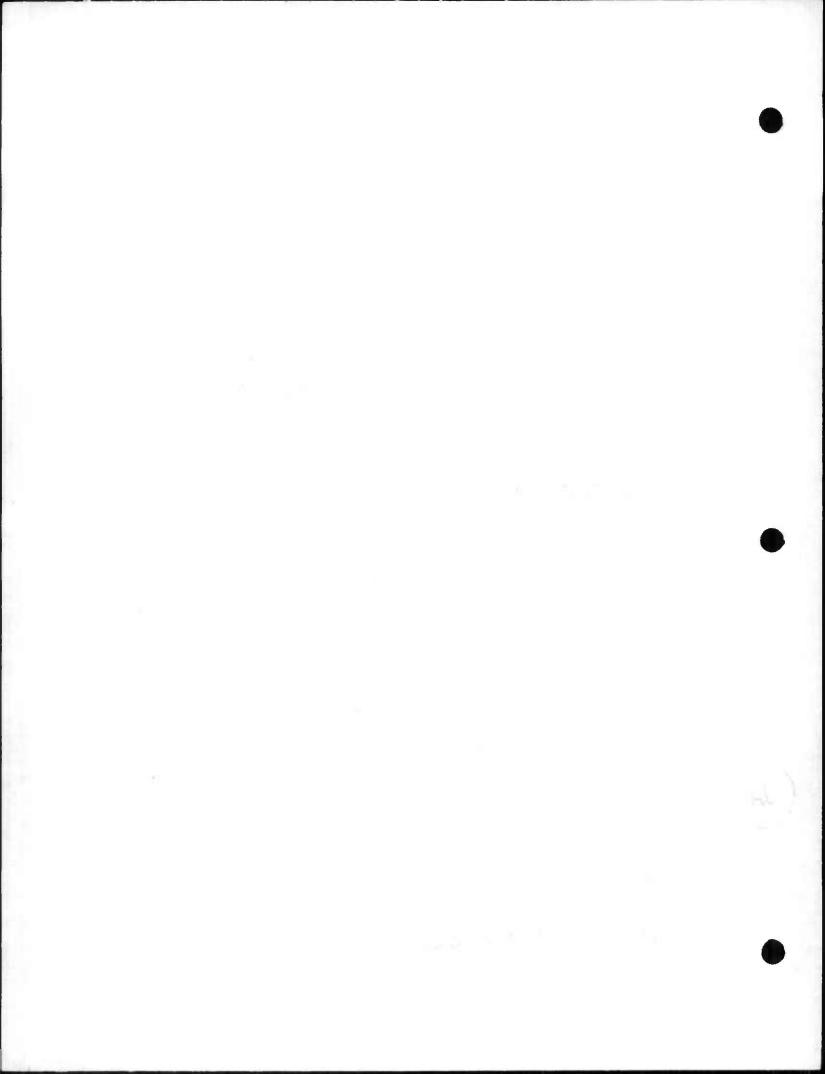
32 REGISTRAR'S SIGNATURE

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BALTIMORE, MARYLAND 21215-0020 SOME THE law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The law requires that the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be the law and higher traumatic event, the medical examiner must be notified at once.	
DAYSION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL DE ALTERNORM. The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hosp TO THE FAMENAL ARTERIOR. After the State Degr. of Health and Mental Hydiene prior to burial, cremation, or removal. IMPORTANTE, It farm 25 the marked, or them 23 shows any Injury, or either traumatic event, the medical examiner must be notified at once.	

	1 - STATE REGISTRAR		CE	RTIF	ICAT	E OF	DEA	TH	VICTO IA	REG. NO	_		
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE	OF DEATN		ī	3. TIME OF DEATH
	WILLIAM	E. DA	AVIS S	R.					MONT	ruan/11		YEAR	12:52 AM
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDE	R t YEAR	IF UNDER	24 HRS.		OF BIRTH	0, 1-1	S. BIRTH	PLACE (State or Foreign
	213-28-8333	1 🕅 M 2 🗌 F	62	YRS.	MONTHS	DAYS	HOURS	MIN.	1 2 -	20-32		Country	YL AND
	9a. FACILITY NAME (If not institution, give str	met and number)			9b. CIT	Y, TOWN D	R LOCATI	ON OF DE		20-72		TY OF DE	
DIRECTOR	BAY VIEW HOSPIT	AL				TIM					J		2011
Ö	10a. STATE 10b. COUNTY			10c. C/1	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY
	MARYLAND			В	ALTI	MOR	E						LIMITS?
AL	10e. STREET AND NUMBER					101	ZIP COD	E			10g. CITIZ	EN OF W	HAT COUNTRY?
EH	415 S. LEHIGH S	TREET				2	122	4			U	SA	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	T EVER IN U.S. ARM YES 2 THE	MED O		WAS DEC	ecify Cuba	OF NISPAN In, Maxicar Specify	n, Puarto	N? (Specify Yes Rican, atc.)	or No-	14. RACE Black Specifi WHI	— American Indian, , Whita, stc. Y:
ED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION COMPRISED	16a. DEC	EDENT'S	USUAL O	CCUPATIO	N .		168	. KIND OF BUS	SINESS/IND	USTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5	1660	Do NOT u	se retired.)	auring mos	ST OF WORK!	10					
MP	6 YEARS		SEW	. M	ACH.	MA	C. E	ELEC	TRI	C LON	DON	FOG	
8	17. FATHER'S NAME (First, Middle, Last)						18. MOT	NER'S NAI	ME (First,	Middle, Maiden	Sumame)		
BE	FRANK DAVIS						EL		ВU				
2	190. INFORMANT'S NAME (Type/Print) MRS. JEANNETTE	DAVIS				S (Street au				TO. M			4
	20a. METHOD OF DISPOSITION 1 Burlal 2 Commetion 3 Ramo	und fanon Cana	20b. PLACE A				me of		DAT	E 20c. LO	CATION — C	ity or Tov	vn, Stata
	4 Donation 5 Other (Specify)		GREE!	Majory of C	JUNT	CE	М		2-	18 BA	LTO.	MD	
	BANGSATURE OF FUNERAL SERVICE LICE	eghes BUN	shi		KA	CZO	ROWS		FUN	ERAL BALTO		2	1224
\neg	23. PART i. Enter the diseases or co ahock, or heart failure. L	ompligations the	t caused the dee	th. Do i	not enter	the mod	de of dy	ng, auch	aa can	diac or reapi	ratory arre	et,	Approximate
	IMMEDIATE CAUSE (Final disease or condition reauting in death)	-	OR AS A CONSED		rock								interval Between Onset and Death
		DUE TO	(OR AS A CONSED	UENCE O	F):								
S	Sequentially list conditions.	AC	ute M (OR AS A CONSEQU	400	ads	N	nto	C-CA	-10-				
Ě	If any, leading to immediate cause. Enter UNDERLYING	DUE TO	(OR AS A CONSEQU	UÉNCE O	F):	-							
윤	CAUSE (Disease or injury	DUE TO	(OR AS A CONSED	HENCE O	E).								
	that initiated events resulting in death) LAST	502 10	(On AS A CONSEDI	DENCE O	rj.								
CERTIFICATION	d.												
DICAL	PART II. Other algnificant conditions	contributing to	deeth but not re	sulting	in the ur	nderlying	ceuse	given in I	Part i.	24s, WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
입						,			-	t 🗆 YES 2	X NO		OF DEATH?
-	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEAT	Ή Ү	SIP	NO IT	UNC	ERTAIN					1 - YES 2 NO
Ž	25. WAS CASE REFERRED TO MEDICAL		26. PLACE				0110					1	
PHYSICIAN: ME		HOSPITAL:	ER/Outpatient 3	DOA	OTHER		5 Re	sidence 8	t Othe	e (Specify)			
ቷ	27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIM	E DF	28c. INJL	IRY AT	alderics (CRIBE HOW IN	JURY OCC	JRED	
ВУР	1 Natural 5 Pending	(Month, De	ay, Year)	INJ	URY M	1 Y	RK? ES 2	ND [
	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE Of	F INJURY — At hom	ne, ferm, i	street, tact	ory, offica	-		281. LOC	ATION (Street a	nd Number o	or Rural Ro	oute Number,
ETED	4 Homicide datarmined	building,	atc. (Specify)						City	or Town, State)			
ן ב	29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	AN: To the best of	my knowledge, deat	th occurr	ed at the t	lme deta	and place	and due t	to the cou	une(s) and man			
COMPL	one) 2 MEDICAL EXAMINER												and manner ea stated.
	296. SIGNATURE AND TITLE OF CERTIFIER	122				- 1		NSE NUM		The second			
BE	Hathler 1	M. K.	di -	mi)	1		350			DATE	SIGNED (Month, Day, Year)
2	30. NAME AND ADDRESS DF PERSON WHO	COMPLETED CAUS	SE DF DEATH (ITEM	27) (Type.	Print)			/30	-		. 0	7/16	/ /
	Kathleen M. Brown M	1D John	s Hopkins			He	Lica	1 Ctr	. 4	940 E	ore.	n Ava	21224
	FEB 1 7 1995	32. REGISTRA	R'S SIGNATURE	,									*



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Flours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - STATE REGISTRAR	STATE OF MARY			F HEALTH AND OF DEATH	MENTAL	HYGIEN REG. NO	_	
		mes	Dye			MONTH	. 14,	(°995 '	3. TIME OF DEATH 1:45a
	4. SOCIAL SECURITY NUMBER 579-01-8710	1 ⊠ M 2 □ F	76 YRS.		HOURS MIN.		Dey, Year)	L918 W	BIRTHPLACE (State or Foreign Country) VashingtonD
TOR	Anne Arundel M. Residence of Decement		nter		wn or location of polis	DEATH		Anne	Arundel
DIRECTOR	10a. STATE 10b. COUNT	Arundel	10c. cr Ed	gewat	ocation er				10d. INSIDE CITY LIMITS? 1 XYES 2 NO
FUNERAL	100. STREET AND NUMBER 245 Munroe Ave	nue			101. ZIP CODE 21037			USA	OF WHAT COUNTRY?
ВУ	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ES 2 NO R DATES	If ye	DECENDENT OF HISP. s, specify Cuban, Mexic YES 2 NO Spec	can, Puerto R		a or No — 14.	RACE — American Indian, Black, White, etc. Specify: White
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 1 2	CATION	18a, DECEDENT'S	work done durings retired.)	g most of working			siness/indust	chants
BE COI	Wilson James D 196. INFORMANT'S NAME (Type/Print)	ye Sr.				e M.	Whit	ce	
0	B. Louise Welc		245	Munro	reet end Number or Rure e Avenue	, Ed	gewat	cer, M	4D 21037
	20e. METHOD OF DISPOSITION 1) Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	ovel from State	Cometeny, crematory or C Lakemon	t Cem	etery				or Town, State
	11. MONATURE OF FUNERAL SERVICE LA	WIA		Har	desty Fu Ridaelv	nera			.A. s,MD 21401
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST	DUE TO (OR A	S A CONSEQUENCE O	un's	n Mag	b	tre		Onset and Das
BY PHYSICIAN: MEDICAL CE	PART N. Other significant condition	s contributing to deat	but not resulting	in the under	tying cause given i	n Part i.	24a. WAS AN PERFOR	HED?	24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	6. PLACE OF DEATH (C	Check only one)		
Y PHYS	1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation	1.2 Inpatient 2 ER/O 28a. DATE OF INJUF (Month, Day, Yea	Y 28b. TIS	JURY 280	Home 5 Residence - INJURY AT WORK? YES 2 NO	_		NJURY OCCUR	RED
	2 Accident Investigation 3 Suicide 6 Could not be determined	26e. PLACE OF INJU- building, etc. (S	JRY — At home, ferm,	street, factory,	office		TION (Street of Town, State)		Rural Route Number,
COMPLETED	one)	CIAN: To the best of my kn							auso(e) end manner ee atated.
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIED 30. NAME AND ADDRESS OF PERSON WH	en mo	DEATH (ITEM 27) (Ton), Print)	29c. LICENSE N			29d. DATE SI	IGNED (Month, Day, Year)
	R. BIZAN 31. DATE FILED (Month, Day, Year)	AAM (. 100/					
	FEB 1 7 1995	ali d'hudear	anlak						OHMH-16 Rev

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death cartificate be executed with a find and an area of the man and the hosp TO THE FUNEDAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
e death certificate the attending physical Hygiene principle of article of ar
s that the
PHYSICIAN: The law require this certificate has been sig- with the State Dept. of He rked, or item 23 shown
D THE HOSPITAL OR ATTENDING THE FUNEPAL DIRECTOR: After 6 filed within 72 hours after death MPORTANT: If item 28 is ma

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ND / DEPARTM			MENTAL HYGIEN		
1	1. DECEDENT'S NAME (First, Middle, Last)	el Du	OVE.			2. DATE OF DEATH	MAY YEA	
	4. SOCIAL SECURITY NUMBER 218-60-9492	5. SEX 6. AGE (In)		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Dey, Year) Jul. 3,	0.8	IRTHPLACE (State or Foreign ountry) Aryland
TOR	90. FACILITY NAME (If not institution, give str Univ. of Mary). RESIDENCE OF DECEDENT	The state of the s	1 4 /	Balt	R LOCATION OF D		9c. COUNTY C	-
DIRECTOR	10a. STATE 10b. COUNTY MD N/A			own or Locat	ION			10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	2	Dali		ZIP CODE		10g. CITIZEN (1 X YES 2 NO
FUNERAL	1605 Spray Court				21217		U.S.	
BY FUR	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 X YES IF YES, GIVE WAR OR DATE	2 NO	If yes, spe	ENDENT OF HISPAI celfy Cuban, Maxics 2 NO Specifi	NIC ORIGIN? (Specify Year, Puerto Rican, atc.) y:		IACE — American Indian, Black, Whita, atc. ipecity: Black
LETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	6a. DECEOENT'S USL (Give kind of work life. Do NOT use re-	done during mo:	NN st of working	Winches	siness/industr ster Sar	IY
COMPL	N/A 2 17. FATHER'S NAME (First, Middle, Last)	yrs.	Laborer	-		Habitat		
	James Dupye					ME (First, Middle, Maiden		
) BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street a		Route Number, City or Tox)
10	Lucille Dupye					imore, Mar		
	20a METHOD OF DISPOSITION 1 M Burial 2 Cremation 3 Remo	00111010	LACEAND DATE OF D	olace)			CATION — City o	
	4 Donation 5 Other (Specify) 21. SIGNATURE OF PUNERAL SERVICE LICE		rison Fo			2-17 Owi	ings Mil	lls, MD
	· Illness	EAR				Home East Avenue/Ba		, MD 21202
	23. PART i. Enter the diseases, or conshock, or heart fallure. L	omplications that caused the course of the course of the course on each	he daath. Do not a	entar tha mo	de of dying, suc	h es cardiac or resp	iratory errest,	Approximete interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Heart	faile	ne				Onset and Daeth
_	_	OUE TO (OR AS A CO	ONSEQUENCE OF):					
NO!	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS A CO	ONSEQUENCE OF):	5		Blen		
CA	cause, Enter UNDERLYING CAUSE (Disease or injury	. Ende ca	udet	SW	ith	Complie	cection	2
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF):			- 1		
	PART ii Other algolficent conditions	contribution to death but		-4-11				
ICAL	PART ii, Other algnificant conditions	contributing to death but	not reaulting in th	e underlying	ceuse given in	PERFO	RMEO?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
PHYSICIAN: MEDIC						□ YES 2	Z NO	OF DEATH?
Ä	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF	DEATH YES	□ NO □	UNCERTAIL	VE I		
CIV		HOSPITAL;	PLACE OF OEATH (C	heck only one) HER:				
HYS	1 YES 2 NO 27. MANNER OF CEATH	1 ☐ Inpatient 2 ☐ ER/Outpatie	ont 3 DOA 4 DOA 28b. TIME OF			8 Other (Specify) 28d. DESCRIBE HOW I	N HIRY OCCURE	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	WOI	ES 2 NO	200. DESCRIBE NOW I	INJUNT OCCUPE	
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, atc. (Specify)	At home, farm, stree	t, factory, office		28f. LOCATION (Street City or Town, State)	and Number or Ru	ral Route Number,
COMPLETED		IAN: To the best of my knowleds						se(a) and manner as stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIER		117841		29c. LICENSE NUM			NED (Month, Day, Year)
TO B	M. Jebyar	uan.	my				D 2/1	3/95
۴	30. NAME AND AODRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH			110	1 6 6 7	^ >	- 01 : 10
	31. DATE FILED (Manth, Day, Year)	32. REPLISTRAR'S SIGNATI	UNIV	1.0f	MOI	TO Spita	PB	LitimienD
	FEB 1 7 1995	Francisco Render Ren	dal					1

8. BIRTHPLACE (State or Foreign Country) Md. Randallstown

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1995

9c. COUNTY OF DEATH

Baltimore

BALTIMORE, MARYLAND 21218	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a first death. Page 6 may be retained by the hospital or atten	DIRECTOR After this cardificate has been stoned by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as
BAI	rurs after dea	in by the fur
		filled
8760,	cuted within	d completely
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	ficate be exer	physician and
S, P.O.	death certif	affending
CORDS	res that the	ioned by the
AL.RE	ne law requi	has been s
DF VIT	PYSICIAN: TI	is carlificate
SION	TENDING PH	DR. After th
NIC	DR ATT	DIRECT

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that

FUNERAL within 72 h IMPORTANT: If

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29b. SIGNATURE AND TITLE OF CERTIFIER

Ane

1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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32. REGISTRAR'S SIGNATURE

TOW JOW

Kaymond

permit. Pages 1, 2, 3 should

the burial-transit

fing physician.

FOR STATE REGISTRAR

1 -

2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) MONTH 2 Jarrett Dorsey 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS 1 3 M 2 F 11/28/1902 92 217-03-6338 9h. CITY. TOWN OR LOCATION OF DEATH 9a. FACILITY NAME (If not institution, give street and number, DIRECTOR Manor Care-Ruxton Towson RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10b. COUNTY Randallstown Maryland **Baltimore** FUNERAL 10f, ZIP CODE 8527 Winands Road 21133 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: FORCES? 1 YES 2 1 Never Merried 2 Merried BY 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade compile (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Concrete 12th once. 17, FATHER'S NAME (First, Middle, Last) Mary Ella Cook Ħ John H. Dorsey BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Janice Dorsey 206. PLACE AND OATE OF DISPOSITION (Name 2/20 90 20a. METHOD OF DISPOSITION OATE must MC Buriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Charles Borromeo Cem 21. SIGNATURE OF FUNERAL SERVICE LICE examiner 23. PART Is given the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause/on each line. medical 0 Metastatic PROSTATE CANCER IMMEDIATE CAUSE (Final the cremation, disease or condition resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF): TOURD NE PHOS'IS
LOVE TO (OR AS A CONSEQUENCE OF): burial, other traumatic CERTIFICATION Sequentially list conditions, prior to t if any, leading to immediate cause. Enter UNDERLYING menia CAUSE (Disease or Injury that initiated events OUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 6 Mental Injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL n signed by the Health and N been signed by the Dept. of Health and m 23 shows any In abetes CHF PHYSICIAN: After this certificate has seath with the State De marked, or item 2 26. PLACE OF OEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) 1 YES 2 NO atlent 2 - ER/Outpatient 3 - DOA 28e. DATE OF INJURY 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 1 Natural 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death water 15 mark BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 8 Could not be determined COMPLETED 4 Homicide

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

10d. INSIDE CITY LIMITS? 1 TYES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE - American Indian, Black, White, etc. Specify: **Black** 16b. KIND OF BUSINESS/INDUSTRY Self-employed 18. MOTHER'S NAME (First, Middle, Meiden Sumame) #10 Sonya Court Randallstown, Md. 21133 20c. LOCATION — City or Town, State Pikesville, Md. LEROY O. DYETT & SON FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVENUE **Approximate** Interval Between **Onset and Death** 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29e. CERTIFIER
(Check only one)

2 SERVICE STANDARD CONTROL OF STA MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) DHMH-16 Rev 1/89

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Month leads the death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)	M E	Escho	me		2. DATE OF DEATH	DAY	YEAR 2:55 M		
	4. SOCIAL SECUÉ/TY NUMBER 133-10-0748 90. FACILITY NAME (If not institution, give str	1 🗆 M 2	82 YRS.	F UNDER 1 YEAR HONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) March 1,	1912	B. BIRTHPLACE (State or Foreign Country) New York		
CTOR	Howard County Ger			Colum		EATH	Committee of the commit	ard County		
DIRECTOR		e County		rown on Locat nawanda	1720		10d. INSIDE CITY LIMITS? 1 YES 2 NO			
FUNERAL	100. STREET AND NUMBER 9 Rochelle Park			101.	2IP CODE 14150		USA	EN OF WHAT COUNTRY?		
ВУ	11. MARITAL STATUS 1 Never Merried 2 Merried XX Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	-A-MO	13. WAS DEC	cify Cuben, Mexica	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)		4. RACE — American Indian, Black, White, etc. Specify: White		
COMPLETED	15. DECEDENT'S EDUC; (Specify only highest grade of Elementary/Secondery (0-12)	ATION completed) College (1-4 or 5+)	180. DECEDENT'S U (Give kind of wo life. Do NOT use Buyer; C	rk done during mos retired.)	st of working	16b. KIND OF BU	tment			
COM	17. FATHER'S NAME (First, Middle, Last)		Dayer, c	MITTULE		ME (First, Middle, Meider		stole		
BE (Thomas Mo	Caffrey	1 2			Kathleen		4		
10	Ms. Marybeth Eber					Route Number, City or Tow Columbia, 1				
	20a METHOD OF DISPOSITION 1 & Burlel 2 Cremetton 3 Remove	val from State 201	D. PLACE AND DATE OF netery, cremetory or other	DISPOSITION (Ne	ne of	DATE 20c. LC		ity or Town, State		
	Donetion 5 Other (Specify) 21. SEGNATURE OF FUNERAL SERVICE LICE	M		Cemete	TV ADDRESS OF FA	Var. 20, 1995	Kenm	ore, New York		
	Y phimaller	Aluk	M00535			1 Home, P				
	23. PANT I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ahock, or heart fallura. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death)									
CERTIFICATION	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST b									
PHYSICIAN: MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PARCE SONE SONE 1 YES 2						RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO		
AN:	DID TOBACCO USE CONTR	BUTE TO CAUSE C			UNCERTAI	N 🗆 📗				
SICI	EXAMINER?	HOSPITAL:		OTHER:	5 Residence	a Other (Specify)				
PH	27. MANNER OF DEATH 14 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME	TY WO	łK?	28d. DESCRIBE HOW	INJURY OCCU	RED		
TED BY	2 Accident Investigation 3 Suicide a Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, atri	M 1 Y		281. LOCATION (Street and Number or Rural Route Number, City or Yown, State)				
COMPLETED		AN: To the best of my know						I. ceuse(e) end menner ee stated.		
BE C	29b. SIGNATURE AND TOTAL OF CENTIFIER				29c. LICENSE NUM			SIGNED (Month, Day, Year)		
10	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) /Type P	rint)	02285	6	reco	casey 14 1985		
	LReag E. Le	ocally don	11058	Little .	RATURENT	Porton 1	Colan	CW 700		
	31. DATE FILED (Month, Day, Year) FEB 1 7 1995	12 REGIST MA'S GIGN	ATUP							

al or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

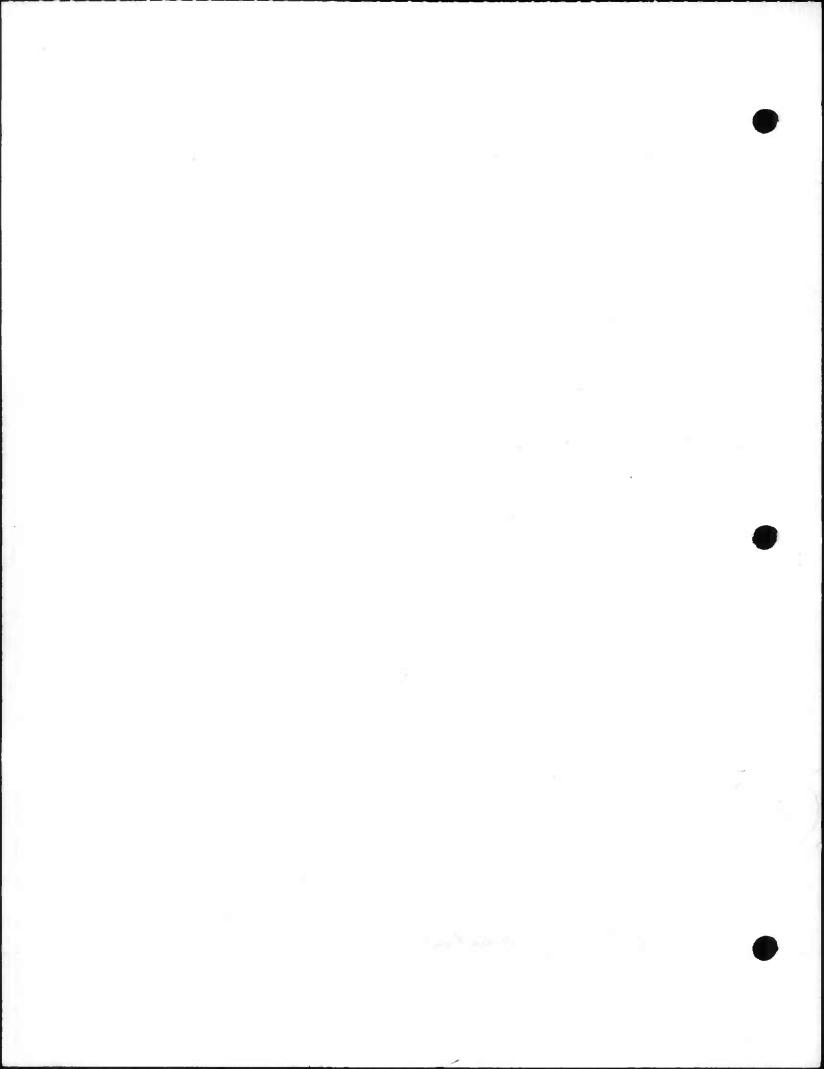
	physician.	burial-transit permit, Pages 1, 2, 3 should		
	NG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should		ner must be notified at once.
	e be executed within 24 hours after death.	sician and completely filled in by the funer	wfor to burfal, cremation, or removal.	traumatic event, the medical exami
	1: The law requires that the death certificat	cate has been signed by the attending phy	h the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	TE HOSPIAL OR ATTENDING PHYSICIAN	HE RUMMAN DIRECTOR: After this certific	ed water 72 hours after death with the S	ORTANT: If item 28 is marked, or I
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	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH								YEAR 3.	TIME OF DEATH		
	CHARLES mar		DIETRICH					GED 10 1990 11:00				
j	4. SOCIAL SECURITY NUMBER 218–28–2318	5. SEX 6. AGE	(In yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	(Month	Dey, Year)		Country)	ACE (State or Foreign		
- 1	9e. FACILITY NAME (If not institution, g	1 //	Tho.	95 CITY TOWN	OR LOCATION OF D		ARY 19,		NHEELI TY OF DEAT	NG,W. VA		
STOR	5105 Cynthia Cou			BALTIMOR		EAIR		BALTI		Н		
DIRECTOR	MARYLAND BALT	TIMORE		TOWN OR LOCAL					- 1"	d. INSIDE CITY LIMITS? YES 2 X NO		
FUNERAL	100. STREET AND NUMBER 5105 CYNTHIA COURT				21206			10g. CITIZI	EN OF WHA	T COUNTRY?		
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 X Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 TYES IF YES, GIVE WAR OR D	2 X NO	If yes, sp	ENDENT OF HISPA ecify Cuben, Mexica 2 NO Specif	en, Puerto R		14. RACE — American Indian, Black, White, atc. Specify:				
COMPLETED	15. DECEDENT'S (Specify only highest g Elementary/Secondary (0-12)	EDUCATION rade completed) College (1-4 or 5 +)	16a. DECEDENT'S U (Give kind of we life. Do NOT use	ork done during me	ON st of working	16b.	KIND OF BUS	INESS/INDU		WHITE		
MP	10		OPERATING	ENGINEER		CHE	BRY HI	T CONS	STRUCT	TON		
	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA		liddle, Maiden	Sumame)				
H	GERALD DIETRICH 19a. INFORMANT'S NAME (Type/Print)		19h MAII ING	ADDRESS (Street	SARA THOP	NBURG		0 7:- 0				
2	RANDY S. DIETRICH				BALTIMORE.				<i>i</i> 000)			
	20e. METHOD OF DISPOSITION 1 Buriel 2XX Cremetion 3 5		. PLACE AND DATE OF	F DISPOSITION (No	me of	DATE	20c. LO	CATION - CI	ity or Town,	State		
	4 Donation 5 Other (Specify)	IVIE	TRO°CREWATO	RY"INC. F	EBRUARY 11	1, 1995	BALT.	MORE,	MARYL	WD		
	21. SIGNATURE OF FUNERAL SERVICE	Pureral Hon	PE	Lassa	n Funer: Belair R	al Ho		re Md	212	36		
	23. PART I. Enter the diseases,	or complications that cause ire. List only one cause on a	d the deeth. Do no	ot enter tha mo	de of dying, suc	ch as cerd	lec or reapl	ratory arre	st,	Approximata		
	IMMEDIATE CAUSE (Final disease or condition resulting in death)		a consequence of:							Interval Between Onset and Daath		
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):											
PHYSICIAN: MEDICAL	PART II. Other significent condi	tione contributing to deeth to	out not resulting in	the undariyin	cause given in	Pert I.	24a. WAS AN PERFOR 1 YES 2	MED?	CD OF	RE AUTOPSY FINDINGS AILABLE PRIOR TO IMPLETION OF CAUSE DEATH? YES 2 NO		
Z	DID TOBACCO USE COI	NTRIBUTE TO CAUSE C	F DEATH YES	ON D	UNCERTAI	N 🛭			'			
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	(Check only one)								
IXSI	1 TES 2 NO 27. MANNER OF DEATH	1 - Inpatient 2 - ER/Out	patient 3 DOA	4 - Nursing Horr	5 (nasidence							
	1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	266. TIME INJU	RY WO	RK?	28d. DEŞ	CRIBE HOW IF	JURY OCCU	RED			
2 Accident Investigation 1 YES 2 NO							r Rural Rout	e Number,				
COMPLETED		HYSICIAN: To the best of my know								ed manner as states		
	SHOWATURE AND TITLE OF CERTI				29c. LICENSE NUI			29d. DATE,				
) BE	Afanta Gellan V	Drote Michi Di	BANNINA		D0167			► GA	10.19	190		
임	30. NAMELING ADDRESS OF PERSON		ATH (ITEM 27) (7) e, /						1.,			
ļ	Dr. Stanley Z. Fo	elsenberg 11	Chase	St. Bal	timore,	Md.	(837-4	324)				
	31. FEBE 1 1905	Cales per handle side 9 46	AYURE									

STATE OF	MARYLAND / DEPARTMENT	OF HEALTH AND	MENTAL HYGIENE
	CERTIFICATE	OF DEATH	REG NO

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Lest) HOWARD	EVANS				2. DATE MONTH	OF DEATH		EAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 241-28-9820	5. SEX 1 1 M 2 1 F 73		UNDER 1 YEAR OTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE Month	OF BIRTH			HACE (State or Foreign
TOR	96. FACILITY NAME (# not institution, give si	dica Cer	nter "	Balt	-IMOR			9c. COUNTY	OF DE	ATH
DIRECTOR	Maryland 106. COUNTY		Ba	WN OR LOCAT	on nore					10d. INSIDE CITY LIMITS? 1 VES 2 NO
FUNERAL	10. STREET AND NUMBER 6842 Westr 11. MARITAL STATUS	idge Rd.		2	1207			US	SA	HAT COUNTRY?
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	12. MA DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	₽ ¶0	If yea, spe	ENDENT OF HISPAL ecity Cubert, Maxica 2 W NO Specif	nn, Puarto F	I? (Specify Yes Rican, atc.)	or No-	RACE Black, Specify	- American Indian, Whita, atc.
COMPLETED	15. DECEDENT'S EDU((Specify only highest grade Elementary(Secondary (0-12)	CATION completed) College (1-4 or 5+)	Give kind of work life. Do NOT use ret	done during mos	N It of working	16b.	KIND OF BUS	SINESS/INDUS	TRY	
	17. FATHER'S NAME (First, Middle, Lest)	0 0	lone		18. MOTHER'S NA	AME (First, A	Aiddle, Maiden	Surname)		
TO BE	199 INFORMANT'S NAME (Type/Print)	2115	19b. MAILING ADD	DRESS (Street or	nd Number or Rural	- (or, City or Tow	n, State, Zip Co	M)	21207
	20e. METHOD OF DISPOSITION 1 W Burlel 2 Cremetion 3 Remo	ovel from State connector	ACE AND DATE OF DI	SPOSITION (Nai	2114	2 PATI	20c, LO	CATION - CIN	1º1a	n, State
	4 Donation 5 Other (Specify)	ENSEE PY	<u>es</u> 1	22. NAME AN	D ADDRESS OF FA	GILITY USS	<u>ъпо</u> Fu	nera		lome
\dashv	23. PARTY Enter the diseases, or o	complications that caused the	e daeth. Do not a	2223	W. Nor	th as card	Ve, B	ratory arrest	Md	, 21216 Approximata
	iMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. Bilate		ا سر فحد	moni	4				interval Between Onset and Death
Z	Sequantially list conditions,	DUE TO (OR AS A CO	NSEQUENCE OF):	elm-	vanew	(a_	A	caid.	en!	
CATIC	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A CO.	NSEOUENCE OF):							
CERTIFICATION	that initieted events resulting in death) LAST	DUE TO (OR AS A COI	NSEOUENCE OF):							
AL	PART II. Other significent condition	s contributing to death but n	not reculting in th	ne underlying	cause given in	Part I.	24a. WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR	RIBUTE TO CAUSE OF D	DEATH YES I	⊐ № □	UNCERTAI	 N []				OF DEATH? 1 YES 2 NO
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		PLACE OF DEATH (C	heck only one)						
	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c, INJU	RK?			YJURY OCCUR	IED	
1 Matural 5 Pending Investigation 2 Accident 2 Accident 3 Suicide 8 Could not be determined determined 4 Homicide Homicide Homicide Accident 2 Accident 2 Accident 2 Accident 3 Suicide 8 Could not be building, stc. (Specify) 28s. PLACE OF INJURY — At home, farm, strast, factory, office City or Town, State) 28s. LOCATION (Street and Number or Rural Route in City or Town, State)							ute Number,			
COMPLET	29a. CERTIFIER (Check only	CIAN: To the best of my knowledge	e, death occurred at	the time, data	and place, and due	to the cau	se(a) and man	ner as stated.		
	one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER	R: On the basis of axamination and	d/or investigation, in	my opinion, de	ath occured at the		and place, an			
TO BE	R. m. shal ma				Diac		~			Month, Day, Year)
٦	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DEATH	(ITEM 27) (Type, Print	1 ht	- ME	. 1	zalti	more	e . r	u D
	FEB 1 7 1995	32. REGISTRAR'S SIGNATUR	RE		·	,				
	LEDT (1999 X	hi devolver level	<u> </u>							1

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.	
1	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIM	E OF DEATH
1 2	ANTOINETTE EICHHORN FLB 16 1995 11.	20 A. M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE	(State or Foreign
	217-09-1194 1 M 2 FF 75 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) Country) MARCH 13 1919	ARULAND
	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH	
E	GOOD SAMMITAN HOSPITAL PALTIMORE	
<u> </u>	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY 10c, CITY, TOWN OR LOCATION 1nd II	NSIDE CITY
DIRECTOR	1 March 12 12 13 15 15 15 15 15 15 15 15 15 15 15 15 15	IMITS? YES 2 1 NO
1	10s. STREET AND NUMBER 10g. CITIZEN OF WHAT CI	
ER/	8917 QVONDALE Rd 21234 U.S.	A-
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No — 14. RACE — Am	erican Indian,
BY F	1 Never Married 2 Married FORCES? 1 YES 2 NO II yes, specify Cuban, Mexicen, Puarto Rican, etc.) 1 YES, GIVE WAR OR DATES Wildowed 4 Divorced Divorc	1 & 1
		RIVE
COMPLETED	(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired)	
12	Elementary/Secondary (0-12) College (1-4 or 5+) SAUSAGE LIAIKEE ESSKAY MEA	7-7-S
OM	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)	
BE C	CARMEN TROTTA FILOMENA Ruggie	no
	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2	1234
2	Lewis W. EICHHORN 8232 LAUREL DRIVE BALTOR	12
	20s. MSTROD OF DISPOSITION 20s. MSTROD OF DISPOSITION (Name of Company of other place)	ta
	1 Donation & Dother (Speny) 1 DACRED Itt. of Jesus 2-20 DA It was no	MQ
	21. SIGNATURE OF FUNEBAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY TOSCPL N. ZANNINO TR. Fune	of House
	May Janna 263 5. Conkling St. BAlto MA	21774
П	2. PART Letter the complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Approximata
	IMMERIATE CAUSE (SHIA)	ntarvai Between Onset and Death
	resulting in death) Respiratory Forwer Due to (or as a consequence of):	
NO N	Sequentially has exhibitions, Due to (or as a consequence of):	
Y.	cause. Enter UNDERLYING	
Ē	CAUSE (Disease or Injury that initiated evanta DUE TO (OR AS A CONSEQUENCE OF):	
CERTIFICATION	resulting in death) LAST	
0	PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE	
N S	PERFORMED? AVAILA	AUTOPSY FINDINGS BLE PRIOR TO LETION OF CAUSE
MEDI	M. Kal marra tetra	ATH?
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN	ES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF GEATH (Check only one)	
PHYSICIAN:	EXAMINER? 1 Pres 2 NO 1 Inpetiant 2 PR/Outpetiant 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)	
[높]	27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. OESCRIBE HOW INJURY OCCURED	
ВУБ	L Natural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO	
ED E	3 Suicide 6 Could not be 26s. PLACE OF INJURY — At home, term, streat, factory, office building, stc. (Specify)	mber,
	4 Homicide determined	
131	29a. CERTIFIER (Check only LERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as attend.	
COMPLET	one) 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and m	anner as stated.
l m l	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month,	Day, Year)
TO B	76shillas MD D45876 > 2/16/95	
=	30" NAME AND ADORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
	NISHI DAS, 9105 Franklin Square Dr Scute 309 Baltimore Md 2	1237
	FEB 1 7 1995 Julia Studie	
	I FO T (1999) And Commercial and the second	



DIVISION OF VITAL RECORDS, P.O. BOX 68760

30. NAME AND ADDRESS OF PERSON WHO

7 1995

nirotto 31. DATE FILED (Month, Day, Year)

FEB

IPLETED CAUSE OF DEATH (ITEM 27) (Type, Print,

2. REGISTRAR'S SIGNATURE

Dender Realiste

Items#1.19.a.G-film 720 per F.H 2/17/95 P.C STATE OF MARYLAND / OEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Migdle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Elefth 20 5 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE /State or Foreign NOV. 8. 214-62-9497 42 DAYS 1 X M 2 - F 1952 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Johns Hopkins Bayview Center DIRECTOR Baltimore City RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Baltimore City 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3208 Ramona Avenue 21213 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-II yes, specify Cuben, Maxican, Puerto Rican, etc.) FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married ΒY 1 TES 2 NO Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) Proprietor Deli 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Kyrillos Eleftheriou Mary Pozoulakis BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleftheriou 2 Frances L. Elefthero 4006 Balfern Avenue Baltimore, Md. 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 1 [X] Burial 2 Cremation 3 Ramoval from State 4 Donetion 5 Other (Specify) Greek Orthodox Cem. 2/20/95 Baltimore Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Milton J Knight Jr Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, Md. 21214 23. PART I. Enter the diseases, or complications that clused the seath. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata interval Between **IMMEDIATE CAUSE (Final** Onset and Daath disease or condition nagou reaulting in death) 15 d DUE TO (OR AS A CONSEQUENCE OF): 15 d CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING verwhe CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION DF CAUSE MEDICAL Faile 1 - YES 2 NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🖾 UNCERTAIN 🗆 PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? OTHER: 125 YES 2 | NO postient 2 ER/Outpatient 3 DOA ng Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY 28b. TIME OF 28c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY 1 Natural 1 YES 2 NO BY Accident Investigation 28s. PLACE OF INJURY — At home, larm, street, lactory, office building, stc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the ol examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated 296. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 盟 2

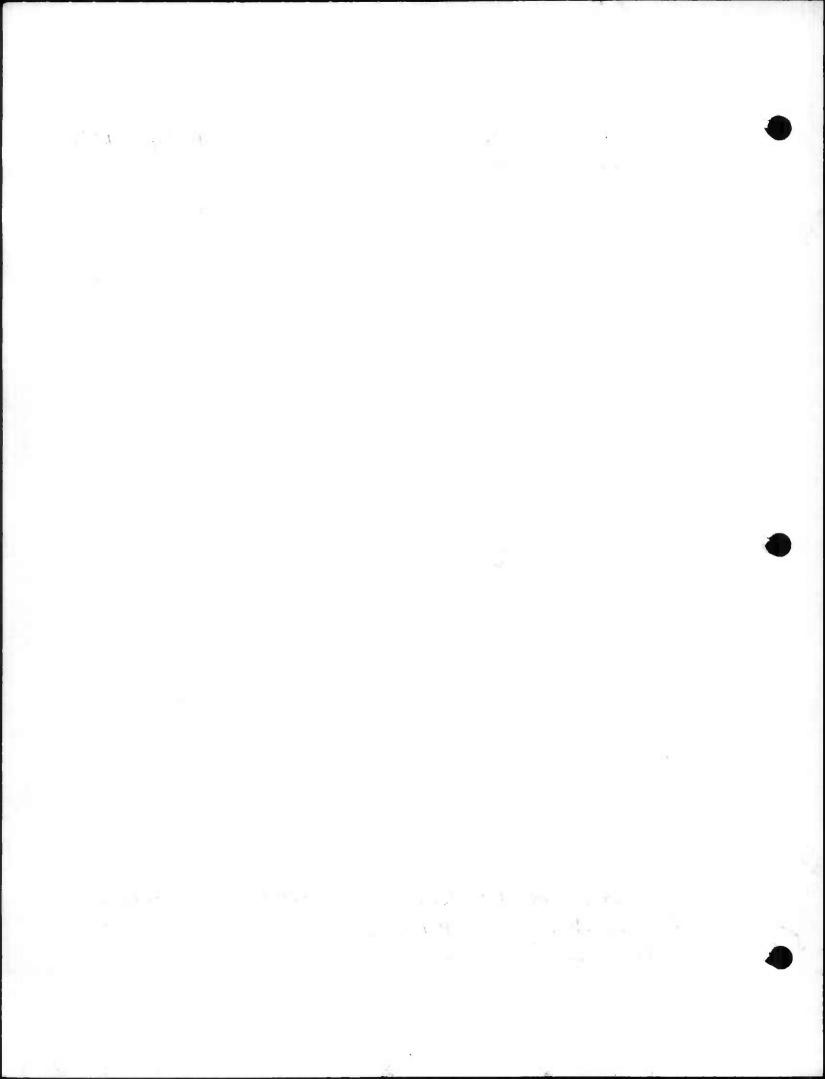
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-Sours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.										
1	1. DECEDENT'S NAME (First, Middle, Last)	FRMER		2. DATE OF DEATH	1991	3. TIME OF DEATH					
	4. SOCIAL SECURITY NUMBER	BIRTHPLACE (State or Foreign Country)									
R	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH										
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	10c. CITY,	TOWN OR LOCATION	215	Da	10d. INSIDE CITY					
	10e. STREET AND NUMBER	B	101. ZIP CODE	LIMITS? 1 X YES 2 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY							
FUNERAL	11, MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED	13. WAS DECEMBENT OF HISPA	24	U	SA					
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	If yes, specify cuban, Maxic	sn, Pusito Rican, etc.)	TOT NO.	RACE — American Indian, Black, White, stc.					
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)		k done during most of working	16b. KIND OF BU	SINESS/INOUST	RY					
MPL		Nurair	n Hasistan								
	17. FATHER'S NAME (First, Middle, Last)	- G	18. MOTHER'S N.	AME (First, Middle, Maiden	Surname)						
BE	19a. INFORMANT'S NAME (Type/Print)	19b, MAILING A	DORESS (Street and Number or Rural	Boute Number City or Tru	Shan Zin Con						
10	WandaSan	ruels 2061	V. Straeper	St. Ba	to. 1	4D21224					
	20s_METHOD OF DISPOSITION 1) Burisl 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	- Riva len	r place)	PATE 200. LO	CATION CHY	or Town, State					
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE	22. NAME AND ADDRESS OF F	KILITY & JO	nesF	urseral Home					
Щ	Seruck	- ka	4/01/ Park	Heightsi	tre. Ba	HO. HD 21215					
	anock, or neert lallure. Li	emplications that caused the deeth. Do not lat only one cause on each line.	entar the moda of dying, suc	ch as cardiac or resp	ratory arreat,	Approximata Interval Between					
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR AS A CONSEQUENCE OF):				Onset and Death					
2	3. 30.04E.3. 30** 30.00 € 5	DOE TO (ON AS A CONSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING	DUE TO (OR AS A CONSEQUENCE OF):									
TIFIC	CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST	DUE TO (OR AS A CONSEQUENCE OF):									
CE	d.										
CAL	PART II. Other significant conditions	contributing to deeth but not resulting in	the underlying ceuse given in	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE					
MEDIC	1			1 TYES 2	PNO	OF DEATH?					
N.											
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: 0	26. PLACE OF OEATH (CI	neck only one)							
HYS	1 VES 2 NO	1 Inpatient 2 FR/Outpatient 3 DOA 4 28s. DATE OF INJURY 28b. TIME O	□ Nursing Home 5 □ Rasidence PF 28c. INJURY AT	8 Other (Specify) 28d. OESCRIBE HOW I	N.II IRV OCCURE	0					
ВУ Р	1 Naturel 5 Pending 2 Accident Investigation	(Month, Day, Year) INJUR	WORK? M 1 VES 2 NO	Loc. Octombe now (TOOM OCCORE						
D 2 Accident 3 Suicide 8 Could not be determined determined 4 Homicide determined											
MPLET	29s. CERTIFIER (Check only one)	AN: To the best of my knowledge, death occurred a	it the time, dets and place, and du	to the cause(s) and man	iner as stated.						
SO	2 MEDICAL EXAMINER:	On the basis of examination and/or investigation, i	n my opinion, death occured at the	time, dats and place, an	d due to the car	use(s) and manner as stated.					
8	296 SIGNATURE AND TITLE OF CERTIFIER	Deputy Metra Promisor	29c, LICENSE NU	MBER	29d. DATE SIG	INED (Month, Day, Year)					
2	30. NAME XNO ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Pri	(ii) \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		0.07	41111					
	31. DATE PILED (POOR), Day, New?	TO REGISTRAT'S SIGNATURE	societ LRG								
	FEB 1 7 1995	Jelin atwalson Restall	b								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. So hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769

	REGISTRAN			ERIIF	ICAII	E UF	DEAL	П	RI	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) KENNETH	Durwo	OD d			F	ORD		2. DATE OF D MONTH FEB	DA	1995	YEAR	3. TIME OF DEATH 11:30P M
	4. SOCIAL SECURITY NUMBER 218-34-1980	5. SEX	6. AGE (In yrs. 53	lest birthdey) YRS.	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF (Mon) Dec. 14	7TH 3Monr) , 194	1	Countr	PLACE (State or Foreign Y) YLAND
	Sa. FACILITY NAME (If not institution, give at	reet and number)			9b. CITY	Y, TOWN (R LOCATIO			,		NTY OF D	
DIRECTOR	75 WINDY FALLS	S (C)			CO	CKE	YSVI	LLE			BA	LTI	MORE.
E	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION		*				10d. INSIDE CITY
	MARYLAND BALTI	MORE		coc	KEYS								1 YES 2 NO
FUNERAL	75 C Windy Fall	S				101	ZIP CODE	030			USA	ZEN OF W	HAT COUNTRY?
5	11. MARITAL STATUS	12. WAS DECEDEN			13.	WAS DEC	ENDENT O	F HISPAN	IIC ORIGIN? (Sp	ecify Yea		14. RACE	- American Indian,
B⊀	1 Never Married 2 Married 3 Widowed 4 Never Married	IF YES, GIVE Y	YES 2 S	Дио			ecify Cuba 2 □XIO		n, Puerto Ricen,	, etc.)		Special WHI	, White, etc. TE
	15. DECEDENT'S EDUC (Specify only highest grade	CATION Completed)	16a.	DECEDENT'S (Give kind of	USUAL O	CCUPATIO	ON .	_	16b. KIND	OF BUS	INESS/IND	USTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5	·)	ruck	se retired.)	4.765	SI OF WORKE	9	П	1 4			
8	17. FATHER'S NAME (First, Middle, Last)		1 1	Tuck	DLIA	eI	40. 44071	APRIO 1111		ucki			
S		es Ellwo	od Ford	!			16. MOTP		ME (First, Middle, na May				
H	19a, INFORMANT'S NAME (Type/Print)				ADDRES	S (Street a	nd Number		Route Number, Ci			Code)	
임	Julie Ann Fo	rd							Hunt				1030
	20e. METHOD OF DISPOSITION 1 □ (Buriel 2 □ Cremetion 3 □ Remo	val from Rtete	20b. PLAC								CATION —		
	4 Donation 8 Dother (Specify)	4	Dula	ney V	alle	у Ме	m.Ga	rden	DATE 18 S FEB	Tim	oniu	n, M	21093
	21. SIONATURE OF FUNERAL SERVICE LIG	Jug CU	LW.(Var	4+ 22.		ID ADDRES		ral Ho	m.o.			
	▶ Bryan W.	Clary			/						monii	ım. Ì	4D 21093
23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardiac or responded in the course of the death. Do not enter the mode of dying, such as cardiac or responded in the course of the death. Do not enter the mode of dying, such as cardiac or responded in the course of the course									4		Interval Between Onset and Death		
	PART II. Other significant conditions	contributing to	deeth but no	t resulting i	n the ur	nderlying	cause g	Iven in i	Part I. 24s.	WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
EDICAL										PERFORI	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEC											tal		OF DEATH? 1 YES 2 NO
	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DE	ATH YE	S 🗆 I	NO 🗷	LUNC	ERTAIN	10/	~~~	cec		
딍	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PL	ACE OF DEAT		_							
Š	1 X YES 2 NO	HOSPITAL:	ER/Outpatient	3 DOA	OTHER		5 X Rei	eldence (8 Other (Spe	cify)			
27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Dey, Year) 28b. TIME OF INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY 1. MANUEL OF INJURY 28d. DESCRIBE HOW INJURY OCCURED													
2 Accident Investigation 2 Accident Investigation 3 Suicide 8 Could not be building, etc. (Specify) 4 Homicide detarmined							oute Number,						
COMPLETED	(Check only one) 1 CERTIFYING PHYSIC One) 2 MEDICAL EXAMINER												and menner ea stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER	1 da					29c. LICE	NSE NUM	BER		29d. DATE	SIGNED	(Month, Day, Year)
TO BE	Denni	J. Chi	ute up				0	.C.N	4.E.				5, 1995
	30. NAME AND ADDRESS OF PERSON WHE	COMPLETED CAUS				eet	Ba] + in	nore,	Mar	יבועי	nd o	1201
	31. DATE FILED (Month, Day, Year)	32. REGISTRA	R'S SIGNATURE		J C. L (Du.		"OTC,	FIGE	ута	1U 2	.1201.
	FEB 1 7 1995 8	The Bender	AND THE PERSON NAMED IN	3									

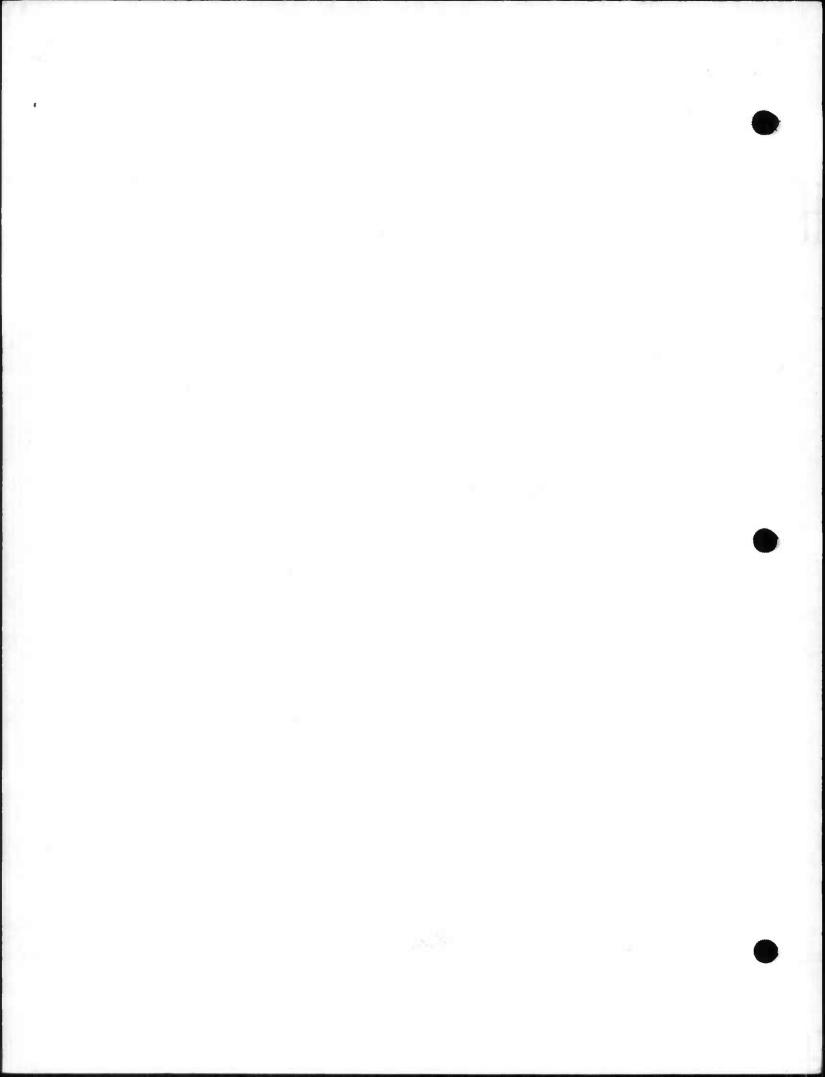
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	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Lest). AMES A- FRANKI	IN	2. DATE OF DEATH MONTH FEBRUARY 15 1995 1035 AM					
	4. SOCIAL SECURITY NUMBER 5. SEX 6 215-32-1882 1 ☑ M 2 □ F		IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Oct. 9, 19	907 BirthPLACE (State or Foreign Country) Maryland			
L	Se. FACILITY NAME (If not institution, give street and number)	1	9b. CITY, TOWH OR LOCATION OF D		9c. COUNTY OF DEATH			
DIRECTOR	Golden Age Guest Home		Sykesville		Carrol1			
EG	10a. STATE 10b. COUNTY	TOWN OR LOCATION		10d. INSIDE CITY LIMITS?				
	maryland Carroll	S	ykesville		1 TES 2 XNO			
RAI	100. STREET AND NUMBER 1442 Buckhorn Road		10f. ZIP CODE 21784	1	10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	S. MARITAL STATUS 12. WAS DECEDENT I		13. WAS DECENDENT OF HISPAN	NIC ORIGIN? (Specify Yea or	United States			
B	1 Never Married 2 Married FORCES? 1 FYES, GIVE WAR		If yes, specify Cuban, Maxico 1 TYES 2 NO Specif	in, Puerto Rican, etc.)	Black, White, atc. Specify: White			
TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give kind of wo	ISUAL OCCUPATION ork done during most of working	16b. KIND OF BUSIN	NESS/INDUSTRY			
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+)	Ret: Mai	retired.) Intenance Worker	Western	n Maryland College			
O.	17. FATHER'S NAME (First, Middle, Last)			ME (First, Middle, Maiden Su	umame)			
BE C	Harvey G. Franklin		Julia	Alice Frank	klin			
2	19a. INFORMANT'S NAME (Type/Print) Mrs. Marguerite Pickett		ADDRESS (Street and Number or Rural Hooper Road Nev					
	20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF	F DISPOSITION (Nama of	DATE 20c LOCA	ATION — City or Town, State			
	↑ Buriel 2 □ Cremation 3 □ Ramoval from State 4 □ Donation 5 □ Other (Specify)	Taylorsvil	Tie Ch. Cemetery	7 2/18 Tay	ylorsville, MD			
	22. NAME AND ADDRESS OF FACILITY Burrier-Queen Funeral Directors, Inc.							
	James D Coo	cepy			Winfield,MD 21784			
	23. PART I. Enter the disease, or complications that should, or heart failure. List only one cause	atiesd the deeth. Do no on each line.	ot enter the mode of dying, suc	th as cerdisc or respire	Intarval Between			
	IMMEDIATE CAUSE (Final disease of condition resulting in death) a. Compession Heart Failure							
	disease or condition resulting in death) a. Concestive Heart Failure Due to (of as a consequence op: Ischewic Heart Disease							
CERTIFICATION	Sequentielly list conditions, if any, leeding to immediate							
S	Cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events Cause Cause Country Cause Cau	ly fluia	alla					
RT								
	PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY ENDINGS							
CAL	TAIL III. Otto agrinout continue continue to the	sear but not reediting in	i the underlying cedee given in	PERFORM	ED? AMPLABLE PRIOR TO			
MEDIC				1 YES 2	OF DEATH?			
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO							
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 DNO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Physipa Home 5 Residence 8 Other (Specify)							
Η	27. MANNER OF DEATH 28a. DATE OF IN	JURY 28b. TIME		8 ☐ Other (Specify) 28d. DE\$CRIBE HOW INJ	JURY OCCURED			
ВУР	1 Naturel 5 Pending (Month, Day,	Year) INJUI	M 1 YES 2 NO					
	3 Suicida 8 Could not be detarmined 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
PLE	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.							
COMPLET	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated.							
BE	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 29d. DATE SIGNED (MO 29d. DATE SIGNED (MO 29d. DATE SIGNED (MO							
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE PATRICK A. TURNOS, MD	Α.	WERSBURG.	MD 21784				
	31. DATE FILED (Month, Day, Year) FEB 1 7 1995 File Office	SIGNATURE		·				



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njury, or other traumatic event, the medical examiner must be notified at once.

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	1 - STATE REGISTRAR	SIAIE UF N			ICATE OI			MENTAL HYGIE REG. N				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH	DAY.	3.	TIME OF OEATH		
	KETH	E			FILHER SP MON			MONTH 2_	MONTH DAY YEAR 95		4 10 M	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	GE (In yrs. lest birthday)				7. DATE OF BIRTH			CE (State or Foreign	
	216 -16-6671	1√2 M 2 □ F	71	YRS.	MONTHS DAYS	HOURS	MIN.	June 6, 1	923	Mary1	and	
	9a. FACILITY NAME (If not institution, give a	street and number)			9b. CITY, TOWN	OR LOCAT			9c. COUNTY OF CEATH			
Œ	Howard County Ger	neral Mos	mital		Columb:	ia			How	ard Co	unts:	
5	RESIDENCE OF DECEDENT	icial nos	prear		COTUNIO.	La			DOWC	aru co	uiicy	
Ä	10a. STATE 10b. COUNT					ATION				104	I. INSIGE CITY	
DIRECTOR	Maryland Howard County Elli				licott (City				1 YES 2 KNO		
	10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHA							T COUNTRY?				
3	4060 St. John's Lane					210	42		US	SA		
FUNERAL	11. MARITAL STATUS	I EVER IN U.S. ARI	IN U.S. ARMED 13. WAS DEC			CENDENT OF HISPANIC ORIGIN		GIN? (Specify Yea or No-		American Indian,		
BY FL	1 Never Married 2 Married IF YES, GIVE WAR OR DATES Wildowed 4 Divorced IF YES, GIVE WAR OR DATES				13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 XNO Specify: Specify Xno Specify:							
	15, DECEDENT'S EDU		16a. DE	CEDENT'S	USUAL OCCUPA	TION	1	16b. KIND OF E	USINESS/IND	USTRY		
E	(Specify only highest grade Elementary/Secondary (0-12)	Coffege (1-4 or 5	Ma	Do NOT L	work done during is se retired.)	nost of work	ing					
4		2		int	er			Newsp	Newspaper			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)							ME (First, Middle, Maid				
	Leonard Keith	Fisher				Ros	aline	one Estel	le Dul	ev		
BE	19a. INFORMANT'S NAME (Type/Print)		191	MAILIN	G ADDRESS (Stree			Route Number, City or 1				
5	Ms. Sandra W. Fis	sher									land 21043	
					SITION (Name of					N — City or Town, State		
	20a. METHOO OF DISPOSITION 1 Burial 2 Decremation 3 Rem	noval from State	other pla	ice)	·					aurel		
	4 Donation 5 Other (Specify) Baltimore-Washington Crematory Feb. 17, '95 Laurrel, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE								L, MD			
	/ plunlallar	Men	_ MOOS	35				al Home, ty, Maryl	P.A. and 21	.043		
	23. PART I. Enter the diseases, of	complications the	at caused the de	ath. Do							Approximate	
	ahock, or haert fallure.	List only one car	use on each lina								Interval Batween Onset and Death	
	IMMEDIATE CAUSE (Final disease or condition		A =		MIL	. 4 -	~ 1	-115-12	201			
	resulting in death)	a	OR AS A CONSE	DUENCE (OF):	-TITO	11194	TOPIA	م الم ي الر الم		FAILER.	
		DUE TO (ON AS A CONSEDURACE OF):										
CERTIFICATION	disease or condition resulting in death) a. A CUTE MYDIAN INFARCATION IMMED. DUE TO (OR AS A CONSEDUENCE OF): NEUtra PERSONAL DIASETES MELLY YRS.											
AT	if any, leading to immediate cause. Enter UNDERLYING											
FIC	CAUSE (Disease Dr Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):											
E	resulting in death) LAST											
S		d										
CAL	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.								ERE AUTOPSY FINDINGS			
							1 T VES 2 TANO		MPLETION DF CAUSE			
1										DEATH?		
2									_ 120 2 _ 110			
PHYSICIAN: MED	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check poly one)											
Š	EXAMINER? HOSPITAL: OTHER:											
17.5	27. MANNER OF DEATH	28a, DATE O	ER/Outpatient 3	28b, TI		NJURY AT	Realdence	8 Other (Specify) 28d. OE\$CRIBE HO	W IN ILIEN OC	CUBED		
à	1 Netural 5 Pending		Day, Year)		JURY	WORK?		280. DESCRIBE NO	W INSURT OC	CONED		
A	2 Accident Investigation					YES 2	□ NO					
		6 Could not be building, atc. (Specify)					City or Town, St	61. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
2	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated.											
COMPL	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated.											
	29b. SIGNATURE AND TITLE OF CERTIFIE	TIFIER				29c, LICENSE NUMBER			29d. DATE SIGNED (Month,		onth. Dav. Year)	
BE	61	100				01-947			2 / 10			
2	30. NAME AND ADDRESS OF PERSON	NAME AND ADDRESS OF PERSON HIS CONTILETED CAUSE OF DEATH (ITEM 27) (Type, Print)						75				
	2/029											
	Warin Thereton my 5540 The 24K an cetershiet, my											
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE											
	1 2 2 1 1330	jeun	Wedger Ro	4.11								
	1 17 4 7			- 4-8							DHMH-16 Rev 1/8	

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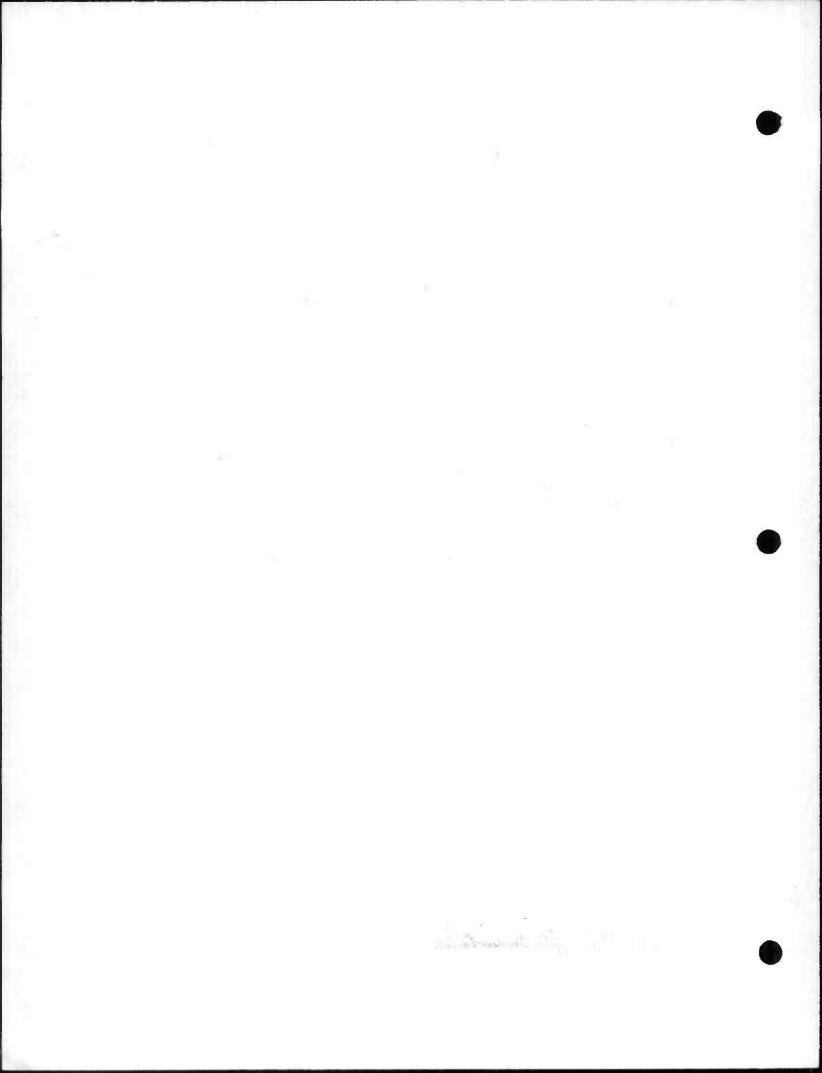
DHMH-18 Rev 1/89

REG. NO

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First Middle Leet 2. DATE OF DEATH 3 TIME OF DEATH Lula Susan FALLIN February 16, 1995 8:50 A M 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAVE 1 M 2 A F 226142388 84 MARCH 10, 910 NORTH CAROLINA Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR FRANKLIN SQUARE HOSPITAL ROSSVILLE Baltimore RESIDENCE OF DECEDEN 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE MD ROSEDALE 1 YES 2 1 NO permit. FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6416 KENWOOD AVE use as the burial-transit 21237 USA retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 № NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried If yes, specify Cuben, Mexican, Puerto Rican, atc.) 1 TYES 2 NO Specify: BY 3 Widowed 4 Divorced WHITE ETED. 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only hi Elementary/Secondary (0-12) page 5 should be detached for College (1-4 or 5 +) COMPL HOME 8 0 HOMEMAKER 17. FATHER'S NAME (First Middle Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) 퓽 BABE MARSH FLORENCE REECE notified 19a INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 BETTY FALLIN 6626 KENWOOD AVE BALTIMORE, MD 21237 hours after death. Page 6 may be 99 20a. METHOD OF DISPOSITION
1 Burlel 2 Cremation 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must 4 □ Donetion 5 □ Other (Specify) BALTIMORE, MD d GARDENS OF FAITH 21. SIGNATURE OF PUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE 21237 the and completely filled in by the burial, cremation, or removal medical 23. PART 1 Each the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, mode, or heart feliure. List only one cause on each line. Approximata Interval Between IMMEDIATE CAUSE (Final **Onset and Death** the diseese or condition resulting in death) Cardiac Arrthymias event. DUE TO (OR AS A CONSEQUENCE OF): Few hows traumatic Myocardial ischemia CERTIFICATION Sequentially list conditions. 2 OUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate the death certificate be signed by the attending physician Health and Mental Hygiene prior to 2 hours cause. Enter UNDERLYING Congestive heart failure CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events DIVISION OF VITAL RECORDS, P.O. 3 years resulting in death) LAST 6 Injury. PART II. Other algnificant conditions contributing to death but not reaulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO Hypertension, Anemia, Non-insulin dependent diabetes any COMPLETION OF CAUSE OF DEATH? 1 - YES 2 1 NO Shows Mellitus, Chronic afibrillation 1 YES 2 NO t. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN IN PHYSICIAN: has by Dept. WB 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The certificate I HOSPITAL: OTHER: DR ATTENDING PHYSICIAN: 1 TYES 2 X NO 1 Inpatient 2 XER/Outpatient 3 I 4 Nursing Home 5 Residence 8 Other (Specify) 10 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED with w marked. 1 K Natural 5 Pending 1 YES 2 NO BY After 1 2 Accident 28e. PLACE OF INJURY — Al home, ferm, streat, lectory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town. Stelle) .00 ED 8 Could not be DIRECTOR: hours after of 4 Homicide 28 determined COMPLET 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. HOSPITAL FUNERAL within 72 h -TO THE HOSPITA
TO THE FUNERAL
Be filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, data end place, end due to the ceuse(s) end manner es stated. 29b, SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER BE 29d. DATE SIGNEO (Month, Day, Year) 9200 D 38754 2-16-95 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Malika Waseem. M.D. 100 N. Broadway Baltimore, MD 21231 31. OATE FILED (Month, Day, Year) 7 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



permit, Pages 1, 2, 3 should be detached for use as the burial-transit the hospital or attending physician. Page 6 may be retained by page & should funeral director, hours after death. by the furfilled in by and completely filled burial, cremation, executed within 9 the attending physician Mental Hygiene prior to death certificate be

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BALTIMORE, MARYLAND 21215-0020

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ITEMS: 7 & 17 per Informant G-722 4/7/95 reb Item22 2-17-95 FilmG720 W.H.Per F/H

ITEM: 7. PER BROTHER FILM G-720 2/21/95 t. FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH February 15 1995 Masud Akhtar Faruqui 4:44 A 7. DATE OF BIRTH 1 2 / 4 / 37 (Month, Day, Year)

APRIL 12 1935 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. BIRTHPLACE (State or Foreign MONTHS DAYS 448-44-3600 1 🕅 M 2 🗌 F 57 YRS. HOURS MIN. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Greater Baltimore Medical Center DIRECTOR Towson Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? BALTO COCKEYSVILLE 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4 THURKILL CT 21030 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Maxican, Pt 1 X YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES COMPLETED BY 3 Widowed 4 Divorced PAKISTANI 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ntary/Secondary (0-12) College (1-4 or 5+) SELF-EMPLOYED 6YRS 12TH COMMUNICATIONS SYSTEM CO 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname, FARUQUI, ABDUS SALAAM ZUBEDA KHATOON BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MOINA R. FARUOUI 4 THURKILLCT. COCKEYSVILLE, MD 21230 ★ Burlal 2 Cremation 3 Removal from State
 Donation 6 Caber (County) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State *KING MEMORIAL PK 21795 Donation 6 - Other (Specify) RANDALLSTOWN, MD OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Nome Den Ja NARCG F/H-WEST 4300 WABASH AVE March 23. PART I. Effer the diseases, or complicatione that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata ock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final **Onset and Death** disease or condition Acute myocardial infarction 2 days resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Atherosclerotic coronary vascular heart disease CERTIFICATION vears Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 X YES 2 - NO OF DEATH? 1 X YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 D Nu ng Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, stc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER

(Chack and)

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TOTLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) llemo mo ofer D27740 ▶ 2/15/95 2 30. NAME AND DORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Robert A. Palermo, M.D. GBMC 6701 N.Charles Street, Baltimore, MD

Jule Wheeler Karlet

RECORDS, P.O. BOX 68760. AL OR ATTENDING PHYSICIAN: The law rec AL DIRECTOR: After this certificate has beer 2 hours after death with the State Dept, of if Nem 28 is marked, or item 23 shi DIVISION OF VITAL

requires that the

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FUNERAL WITHIN 72 h HOSPITAL

TO THE HOSPITA
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IMPORTANT: II

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ITEM: 7 brother came in to make the change on 2/21/95 gave incorrected date of birth reb/gs

Albert march and the state of the

BALTIMORE, MARYLAND 21215-0020

be notified at once

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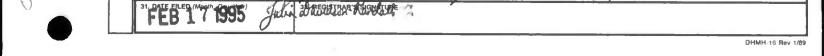
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BOX 68760 DIVISION OF VITAL RECORDS, P.O.

use as the burial-transit retained by the hospital or attending physician. ğ page 5 should be detached ours after death. Page 6 may be director, funeral filled in by the ion, or removal. other traumatic event, the cremation, completely executed with bunal, and Hygiene prior to attending physician The law requires that the death certificate be the atten certificate has been signed by in the State Dept. of Health and 23 Item OR ATTENDING PHYSICIAN: 0 the this c DIRECTOR: After the hours after death with them 28 is mark TO THE HOSPITAL OF THE FUNERAL DE FISE WITHIN 72 PM

Items#19.b20.b Gfilm 720 per F.H 2/17/95 P.C FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT DF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 15^{DAY} MONTH 2 1995 Johnnie Foy 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign 5/8/1932 MONTHS DAYS HOURS MIN Carolina 238-40-4374 1X M 2 | F 62 YRS. N. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 6606 Wycomb Way DIRECTOR (res.) **Baltimore** RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY Maryland **Baltimore** 1 YES 2 | NO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 6606 Wycomb Way 21234 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ★ YES 2 □ NO IF YES, GIVE WAR OR DATES 1/26/53 1/24/55 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, White, atc. yea, specify Cuban, Mexican, Puerto Ricen, etc.) Never Married 2 Married 1 YES 2 NO Specify: Black BY Specify. 3 Widowed 4 Divorced ED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY ost of working ᄪ Sparrow Point Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor 12th COMPI Bethlehem Steel 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Alexander Foy Mary Eliza Spearman 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AD. ISS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 2945 Colfton Avenue Eugene Foy Balto., Md. 21216 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State 1 Burlel 2 Cremetion 3 Removal from State
4 Donation 5 Dother (Specify) Swanns Creek Cem. 2/21 Hope Mills, N.C. 21. BIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE Learn tha diseases or complications that cause of shock, or heart failure. List only one cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ch lina. IMMEDIATE CAUSE (Final Onset and Death disease or condition reaulting in death) DUE TO (OR AS A CONSEQUENCE OF). CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST PART II. Other significant conditions contributing to dath but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 246 WERE ALITOPSY FINDINGS PERFORMED? **AVAILABLE PRIOR TO** PLETION OF CAUSE 1 YES 2 5 100 OF DEATH? T YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER: 1 TYES 2 ENO Inpetient 2 D ER/Outpetient 3 D DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) ZZ. MANNER OF DEATH 264, DATE OF INJURY 286. TIME OF DUJURY 39c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Distured 1 YES 2 NO ВҰ 2 Accident 28s. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Plants Number City or Town, State) 6 Could not be COMPLETED 4 | Homicide



2 MEDICAL EXAMINER: On the basis of examination

29b. SIGNATURE AND TITLE OF CERRIFTER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) end menner as stated.

29d. DATE SIGNED (Month, Day, Year)

29c. LICENSE NUMBER

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FEB 1 7 1995

TO THE HOSPITAL, OR AN ACCIONAL. The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. Are this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 24 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

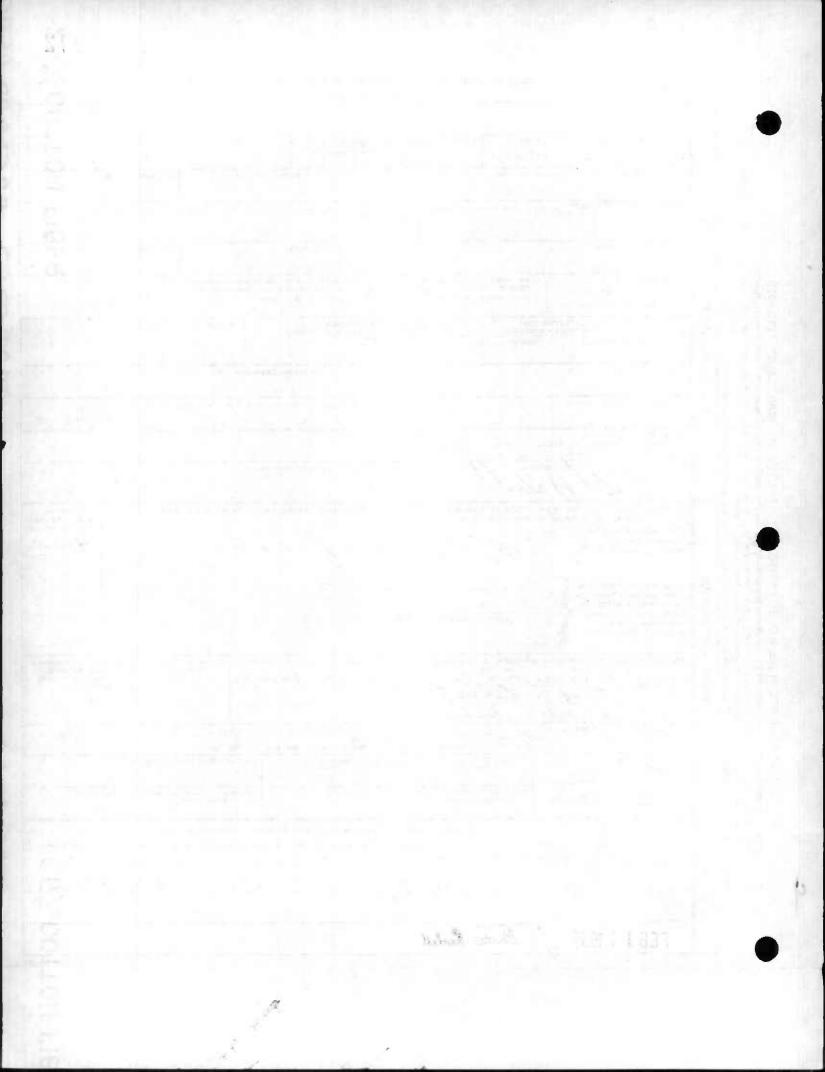
	FOR 1 - STATE REGISTRAR	CERT	PARTMENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) HERBERS	0.000			YEAR SA M			
	4. SOCIAL SECURITY NUMBER 220-03-8333	5. SEX 1 M 2 F F YR:	MONTHS DAYS HOURS ANN		B. BIRTNPLACE (State or Foreign Country)			
OR	ga. FACILITY NAME (If not institution, give :	street and number) Center	96. CITY, TOWN OR LOCATION OF DE	EATH 9c. COUNT	TY OF DEATN			
ECT.	RESIDENCE OF DECEDENT	7	CITY, TOWN OR LOCATION					
L DIRECTOR	Maryland		Baltimore		10d. INSIDE CITY LIMITS? 1 YES 2 NO			
FUNERAL	2422 Pres	bury St.	101. ZIP CODE	10g. CITIZI	S A			
BY FUN	11. MABITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 ☐ YES 2 MNO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPAN If yea, specify Cubin, Mexica 1 YES 2 NO Specify	an, Puarlo Rican, atc.)	14. RACE — American Indian, Black, White, atc.			
0	15. DECEDENT'S EDU (Specify only highest grade		NT'S USUAL OCCUPATION	166. KIND OF BUSINESS/INDU	STRY			
COMPLET	Elementary/Secondary (0-12)		of work done during most of working of use retired.) Temployed					
BE CON	17. FATHER'S NAME (PIST, MIDDIN LOST)	Green	18, MOTNER'S NA	ME (First, Middle, Malden Surname)	-DPN			
TO B	199. INFORMANT'S NAME (Type/Trint)	Henson 160	LING ADDRESS (Street and Number or Pure)	Route Number, City or Town, State, Zip C	1+2 Md 21217			
	20e. METHOD OF DISPOSITION 1 W Burlal 2 Cremetton 3 Rem 4 Donation 6 Other (Specify)	noval from Stata 20b. PLACE AND DA cemete Cemete Community	ATE DE DISPOSITION (Name of yor other place)	2/20/25 20c, LOCATION — CI	Ity or Town, State			
	21. SIGNATURE OF FUNERAL SERVICE LIN	CENSEE	22. NAME AND ADDRESS OF FA	Russ Fyn	eral, Home			
	23. PART i Entar tha diseases, or	complications that caused the death. D	Do not enter the mode of dying, suc	th Ave. Bat	to.Md.21216			
	shock, or fleart failura. IMMEDIATE CAUSE (Final	. List only one cause on each fine.		II so outside or respiratory	Interval Batween Onset and Death			
	disease or condition resulting in death)	a. PNEUMOI						
7.		DUE TO (OR AS A CONSEQUENCE	E DF):					
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (DR AS A CONSEQUENCE	E DF):					
FICA	cause. Entar UNDERLYING CAUSE (Disease or injury that initiated eventa	C. DUE TO (DR AS A CONSEQUENCE	DE DF):					
ERTI	resulting in death) LAST	d.						
	PART II. Other significant condition	ns contributing to death but not resulting	ing in the underlying cause given in		24b, WERE AUTOPSY FINDINGS			
DIC	REMAL FAILUI			PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?			
PHYSICIAN: MEDICA	SEIZURE DISORDER							
IAN	25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE OF DEATH 26. PLACE OF D	YES NO UNCERTAIN	N 🖾]				
SIC	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Notice that 2 ER/Outpetlant 3 DO	OTHER:	8 Other (Specify)				
	27. MANNER OF DEATN 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year) 28b.	TIME OF 28c. INJURY AT WORK?	28d. DESCRIBE NOW INJURY OCCU	PRED			
В В	2 Accident Investigation	28s. PLACE OF INJURY — At home, ter	M 1 VES 2 ND	281. LOCATION (Street and Number or Rural Routs Number				
TED	4 Nomicide 6 Could not be determined	building, atc. (Specily)		City or Town, State)	Figure dic in memorial in year or religions			
COMPLETE		SICIAN: To the best of my knowledge, death occ						
	2 MEDICAL EXAMINE	ER: On the basis of exemination end/or investig			ceuse(s) and manner ee stated.			
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIE	411 10 11	E PHYSICIAL 29C. LICENSE NUN D42-	#BER 29d. DATE 5	SIGNED (Month, Day, Year) 2/16/95			
	30. NAME AND ADDRESS OF PERSON WN 3745 FOX FORD	STREAM ROAD	Type Print) LTIMORE 17	np 21236				

Sheltster 1

BALTIMORE, MARYLAND 21215-0020	urs after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within nous after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Thours after of TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Memtal Hyglene prior to burial, cremation, or removal.

	1 - FOR STATE REGISTRAR	STATE OF MARY		MENT OF HE		NTAL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)				2	DATE OF DEATH	YEA	3. TIME OF DEATH
	Anna Griemsm	ann			F	ebruary 1		
	4. SOCIAL SECURITY NUMBER		E (In yrs. lest birthday)		IF UNDER 24 HRS. 7	(Month, Day, Year)	8. B	RTHPLACE (State or Foreign
	092-30-0356	1 M 2 F	84 YRS.			06-23-10		ermany
_	9e. FACILITY NAME (If not institution, give	street and number)		96. CITY, TOWN OR	LOCATION OF DEAT	н	9c. COUNTY C	OF DEATH
DIRECTOR	NORTH ARUNDEL HOSPITAL GLEN BURNIE A.A.COU							OUNTY
E	10e. STATE 10b. COUNT	Anna Arund	el 10c. CITY	TOWN OR LOCATIO	N			10d. INSIDE CITY LIMITS?
	Maryland	Anna Arund Maryland	Gar	nbrills				1 TYES 2 NO
3AL	10e. STREET AND NUMBER			10f. Z	CIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
NER	510 Timberwood (t Gambrills	Md		1054		US.	A
FUN	11, MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER FORCES? 1 YES	I IN U.S. ARMED S 2 NO	13. WAS DECEN	IDENT DF HISPANIC Ify Cuben, Mexican, I	ORIGIN? (Specify Year	or No- 14, F	RACE — American Indian, Black, White, etc.
BY	3 Wildowed 4 Divorced	IF YES, OIVE WAR OR		1 TYES 2		The thousand arealy		White
ED E	15. DECEDENT'S EDI	I CATION	1					
	(Specify only higheat grad	completed)	(Give kind of we	ISUAL OCCUPATION ork done during most	of working	166. KIND OF BUSI	NESS/INDUSTR	IY
12	Elementary/Secondary (0-12)	College (1-4 or 5+)				Doots		
COMPLET	17. FATHER'S NAME (First, Middle, Last)		Owner/O	-		Restau		
	William Reese					(First, Middle, Meiden S		
BE						igusta (
5	19a, INFORMANT'S NAME (Type/Print)					te Number, City or Town,		•
	Edward H. Gri	emsmann		imberwo	ods Cou			, MD 21054
	20s. METHOD OF DISPOSITION 1 Burial 2 Cremetion 3 Ren		Bb. PLACE AND DATE OF				ATION — City o	r Town, State
	4 Donation 5 Other (Specify)		Metro Cr				ltimo:	re, MD
	21. SIGNATURE OF EUNERAL BERVICE LA	GENSEE ///			ADDRESS OF FACIL		o D	Λ.
	Data H	aux				ral Hom		, MD 21401
CERTIFICATION	disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
AN: MEDICAL CER	PART II. Other aignificant condition		but not resulting in	the underlying of	cause given in Pa	24a, WAS AN A PERFORM 1 YES 2	IED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
N N	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	0,			OF DEATH (Check	unity one)		
Sic	1 TYES 2 PNO	HOSPITAL:		OTHER:	5 - Residence 6	Other (Specify)		
Y PHYSICI	27. MANNER OF DEATH 1 Historial 5 Pending	28s. DATE OF INJURY (Month, Day, Year)	20b. TIME INJU		C7	NA. DESCRIBE HOW IN	JURY OCCURE	0
TED BY	2 Accident 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, term, street, factory, office 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
COMPLET	emal .	ICIAN: To the best of my kno		, in my opinion, deat	th occured at the tim	e, date end place, end	due to the cau	
TO BE	30. NAME AND ADDRESS OF PERSON WI	better :	M.) DEATH (ITEM 27) (Type,		D //	208	PO2	NED (Month, Day, Year)
	Jose M. Presbit FEB 1 7 1995	ero M.D. 32. hegisti Ansisi	7845 Oakwo	od Road.	#100 Gle	en Burnie	Maryl	and 21061



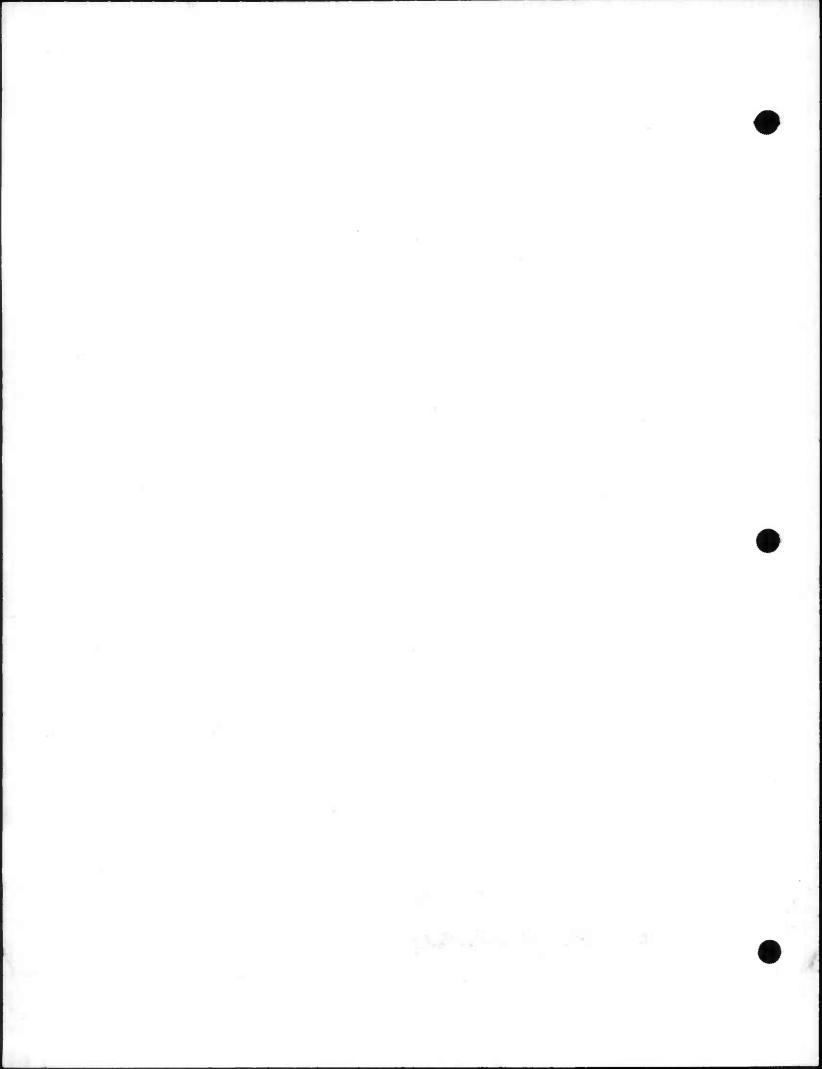
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DIVISION OF VITAL RECORDS, P.O. BOA 86/00 BALLIMORE, MARTLAND 21213-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. 215-0020

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	CATE OF DEATH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF OEATN		3. TIME OF OEATN	
1	BENJAMINE	F. GRO	22		MONTH SAY	YEAR 9.5	1215 AM	
	4. SOCIAL SECURITY NUMBER	7		IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	10	TNPLACE (State or Foreign	
	215-20-4608	1 M 2 F	87 YRS.	ONTHE DAYS HOURS MIN.	(Month, Day, Year)		ntry)	
	9e. FACILITY NAME (If not institution, give	etract and number	0	OTTY TOUR OF LOCATION OF	April 20,1	707	Ma	
CC 1		stroet and number)	10	96. CITY, TOWN OR LOCATION OF E	DEATH	9c. COUNTY OF	DEATH	
DIRECTOR	Good Sama	ritum Ho	Sortal	Dalto				
l iii	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	TV	40- 0177	TOWN OR LOCATION				
<u>E</u>	11/1	• •	2	- AL			10d. INSIDE CITY LIMITS?	
	PIG		Na	100			1 YES 2 NO	
I≅I	100. STREET AND NUMBER	Mursine	Center	101. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?	
FUNERAL	G009601 E	. Reliefer	e Aure	2123	39	11.	54	
5	11. MARITAL STATUS	12. WAS DECEOENT EVE		13. WAS DECENDENT OF NISPA	NIC ORIGIN? (Specify Yes	or No- 14. RA	CE — American Indian,	
1	1 Never Married 2 Married	FORCES? 1 YE		If yes, specify Cuban, Mexic 1 YES 2 NO Spec			ack, White, etc.	
B	3 Widowed 4 Divorced			1 3 1 3 4 3 4 3 4 3 4 3 4 3 4 3 4 3 4 3	,	30	Dack	
유	15. DECEOENT'S ED	UCATION	18a. DECEDENT'S U		166, KIND OF BUSI	INESS/INDUSTRY		
<u></u>	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of wo	rk done during most of working retired.)	Sparnou	W Poin	+	
		comage (1-4 of 5 4)			V2.	Higha		
COMP	17. FATHER'S NAME (First, Middle, Last)			40 MOTHERIO M	NEU		411	
	(Not, Illiano, Lace)			18. MOTNER'S N	AME (First, Middle, Maiden S	iumame)		
BE				(1/6/1/	e, carr			
5	19a. INFORMANT'S NAME (Type/Print)	1	19b, MAILING A	DDRESS Street and Number or Rural	Route Number, City or Town,	State, Zip Code)		
	Edward L.	(710)SS	1971	Pleason H	Il lane h	15/e I	11.60532	
	20e. METNOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Ren		Ob. PLACE AND DATE OF		OATE 20c/LOC	ATION - City or	Town, State	
	4 Donation 8 Other (Specify)	noval from state	semelery cremetory or othe	plece) (Pypten)	12/13/95 Las	neda	in Md	
	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE		22, NAME AND ADDRESS OF F	ACILITY	S (4.00	3, 10	
	- (In In	6/10.1		March F.H.	, yed	.0 ,	7. /_	
	1 Watta.	(MAN)		14300 Wa	wash fre	2-001	14 MY 21215	
	23. PART I. Enter the diseasea, or	complications that caus	sed the deeth. Do no	anter the moda of dying, such	ch as cardlec or respire	etory arrest,	Approximata	
		. List only one cause on	each line.				Opent and Deet	
	IMMEDIATE CAUSE (Fine) disease or condition resulting in death)							
	resulting in death)		S A CONSEQUENCE OF):	\				
		DOE TO (OH A:		ho- 1	0			
S	Sequentially list conditions, if any, leading to immediate D. CRF (m homoduly) OUE TO (OR AS A CONSEQUENCE OF):							
CATION	oue to (or as a consequence of): If any, leeding to immediate cause. Enter UNDERLYING							
	CAUSE (Disease or Injury	c	Hyperh	enten				
쁜	that initiated events DUE TO (OR AS A CONSEQUENCE OF):							
ERTIFI	resulting in death) LAST	d						
O	PART II Other sleetflood on the	no contribution in the contribution of the con	had not					
CAL	PART II. Other algnificent condition		Dut not reaulting in	the underlying cause given in	Part I. 24e, WAS AN A PERFORM		Ib. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
8	Seizune				1 _ YES 2 [COMPLETION OF CAUSE OF DEATH?	
ME	0						1 YES 2 NO	
N.	DID TOBACCO USE CONT	RIBUTE TO CALISE	OF DEATH YES	□ NO □ LINICEDTAL	N [
A	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH		· · ·			
SICIA	EXAMINER?	HOSPITAL:		THER:		· · · · · · · · · · · · · · · · · · ·		
IYS		1 Inpstient 2 ER/O		□ Nursing Home 5 □ Residence				
PH	27. MANNER OF DEATH	28s. DATE OF INJUR (Month, Day, Year			28d. DESCRIBE NOW IN.	JURY OCCURED		
₽	1 Natural 5 Pending 2 Accident Investigation			M 1 YES 2 NO				
	2 Accident 3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, street, factory, office 28f. LOCATION (Street and Number or Rural Route Number,						Route Number,	
=	4 Homicide determined		,,		City or Town, State)			
LET	290. CERTIFIER 1 CERTIFYING PHYS	RICIAN: To the best of our live	nuladas dasti					
MP				at the time, data and place, and dur				
8	A LI MEDICAL EXAMIN	CO. OIL THE DESIG OF EXEMINA	uon end/or investigation,	In my opinion, death occured at the	time, data and place, and	dua to the cause	(a) and manner as stated,	
ш	296. SIGNATURE AND FITLE OF CERTIFIE	ER >		29c. LICENSE NU	MBER	29d. OATE SIGNE	D (Month, Day, Year)	
8	100 NO	N		D311	464	12/1	5197	
2	30. NAME AND ADDRESS OF PERSON WI	HO COMPLETED CAUSE OF I	DEATH (ITEM 27) (Type. P.				010	
	SHOAILS A.	HAS Home,	M.D. 8.	21 N Entran	fe fresto	308	Poltim	
		REGISTRAR'S SIG		0,000	76 0 2000	- 4	1 0-11124	
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EXAMINER?

1 Natural

2 Accident

3 Suicide

4 Nomicide 29e. CERTIFIER

1 TES 2 NO

5 Pending

8 Could not be determined

Investigation

27. MANNER OF DEATN

	Page		
SICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Page	'emoval.	methed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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d by the	ld be del		d at on
e retaine	e 5 shou		notifie
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95 04974 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN 1995 11:00 PM oseph Goldberg February 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday 5. SEX UNDER I YEAR 7. DATE OF BIRTN (Month, Day, Year IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1 🔀 M 2 🗌 F 577-09-9387 83 July 19 Kentucky 9s. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR Suburban Hospital Bethesda Montgomery 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY YES 2 NO Maryland Montgomery Silver Spring FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 11200 Lockwood Drive, Apt. 619 20901 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 2NO 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexicen, Puerto Ricen, atc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES BY 1 YES 2X NO Specify: 3 K Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Yrs Teletype Communication Navy Department 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surneme) Elias Goldberg Goldie Noon BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Allan B. Goldberg 12525 Saint James Road, Potomac, Maryland 20850 20e. METNOD OF DISPOSITION
1 M Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State 2/16/95 PATE 4 Donetion 5 Other (Specify) Mount Lebanon Cemetery Adelphi, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
STEIN HEBREW MEMORIAL FUNERAL HOME, INC. Donald 232 CARROLL ST, NW, WASHINGTON, DC 20012 23. PART I. Enter the diseases, or complications that caused the each ahock, or heart failure. List only one cause on aact line. eath. Do not antar the mode of dying, such as cardiac or respiratory arrest, Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) arter CERTIFICATION Sequantially list conditions, DUE TO JOR AS A GONSEQUENCE OF If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST MEDICAL

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

> February 14,

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | 10

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DI UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL

26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 10 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)

26e. PLACE OF INJURY — Al home, larm, atreet, lectory, office building, etc. (Specify)

28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF

28c. INJURY AT WORK?

28d. OESCRIBE HOW INJURY OCCURED 1 YES 2 NO

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner ee stated.

2 MEDICAL EXAMINER: 0	n the basis of axamination end/or investigation.	, in my opinion, death occured at the time, date end place, er	nd due to the cause(s) and menner ea stated.
A (1			
URE AND TITLE OF CHETIFIES	12	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)

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PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ALMIN S	CHANACE	15225	SHADY	GROUE	RO	ROCKUILLE	MO	20850
24 DATE EU ED AL-								

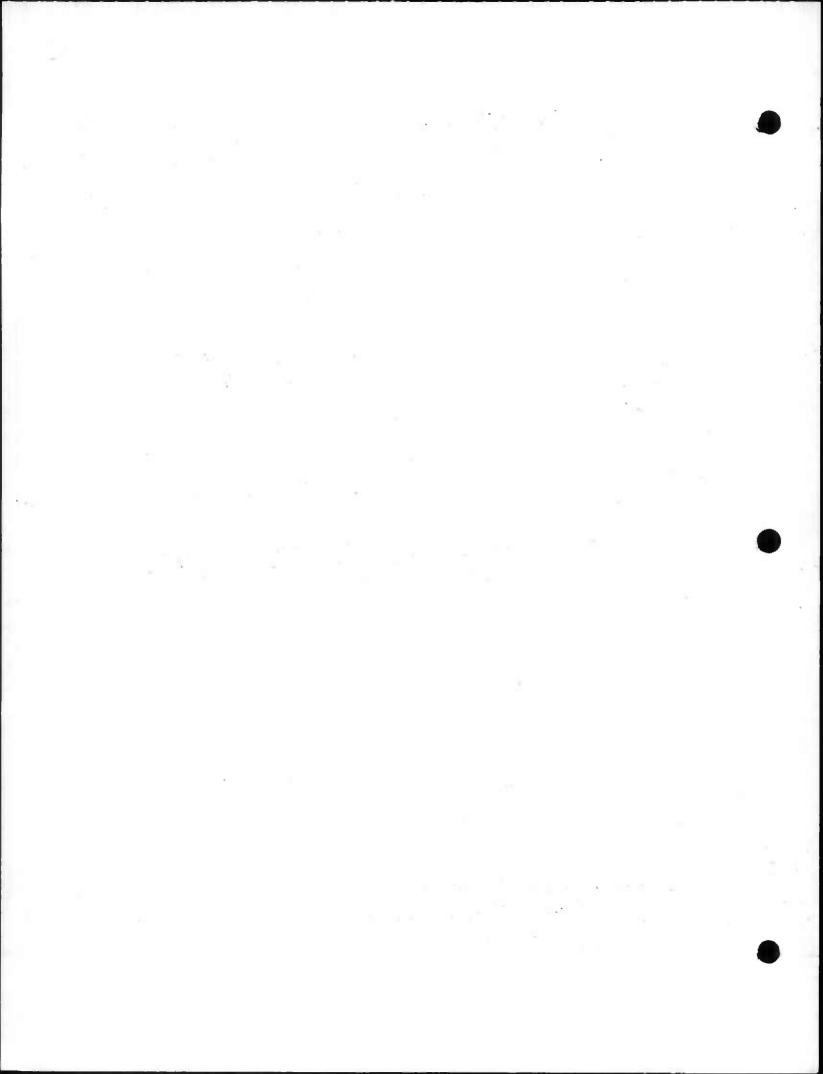
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ION OF VITAL RECORDS, P.O. BOX 68760,	BALTIMORE, MARYLAND 21215-0020
IDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	after death. Page 6 may be retained by the hospital or attending physician.
After this certificate has been signed by the attending physician and completely filled in by the foreath with the State Dept, of Health and Mental Hypiene prior to bunial, cremation, or removal.	After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should death with the State Deot, of Health and Mental Hydiene prior to burial, cremation, or removal.
s marked or item 23 shows any injury or other traumatic event the medical evaminer must be notified at once	les evenine must be notified at once

	1 - STATE OF M	ARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
	1. DECEDENT'S NAME (First, Middle, Last)	ROUE	2. DATE OF DEATH MONTH DAY OF THE OF DEATH THE OF DEATH THE OF DEATH THE OF DEATH THE OF DEATH THE OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX	8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Mgrith, Mgr, Year) Country)
	2 18-82-7 107 1 M 2 15 F	9b. CITY, TOWN OR LOCATION OF D	1/31/63 WEST VIRGINIA
10R	WAShington County /	toppetion tagerstown	eath Oc. COUNTY OF DEATH WAS high for
DIRECTOR	10a. STATE 10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d, INSIDE CITY LIMITS?
	MARYLAND WASHINGTON 100. STREET AND NUMBER	HAGERSTOWN	1 X YES 2 NO
FUNERAL	665 OAK HILL AVENUE	101. ZIP CODE 2 1 7 4 0	U.S.A.
J.	11. MARITAL STATUS 12. WAS DECEDENT		NIC ORIGIN? (Specify Yea or No. 14. RACE — American Indian,
BY	3 Widowed 4 Divorced IF YES, GIVE W		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working	16b. KIND OF BUSINESS/INDUSTRY
PLE	Elementary/Secondary (0-12) College (1-4 or 5+)	ANIMAL RESEARCH TECHNICI	AN R. O. W. SCIENCES
COM	17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NA	ME (First, Middle, Maiden Surname)
1111	LEWIS E. GROVE 19a. INFORMANT'S NAME (Type/Print)	REVA T	
TO BE	MS. ROBIN GROVE	665 OAK HILL AVENUE,	
	20e METHOD OF DISPOSITION ALL Burlet 2 Cremetton 3 Removel from State	20b. PLACE AND DATE OF DISPOSITION (Name of cametery, cremetory, or other clace) CENTRAL CHAPEL CEMETERY	DATE 20c. LOCATION — City or Town, State
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FA	2/14 RFD HEDGESVILLE, WV
	· Charles My		HOME, 327 W. KING STREET ARTINSBURG, WV 25401
	23. PART I. Enter the disesses, or complications that shock, or heart fellure. List only one cause	caused the desth. Do not enter the mode of dving, suc	h as cardiec or respiratory arrest, Approximete Interval Between
	MINEDIATE CALICE (CI)	AND A. 1000 ONE O	Onest and Dooth
	resulting in death) a. DUE TO (or as a consequence of: Alcoholic INto	2 LNJWyy
N O	Sequentially list conditions, b. Houl	OR AS A CONSCIUENCE OF:	XICATION
CATI	If sny, lesding to immediate cause. Enter UNDERLYING	on as a consciouence or):	
CERTIFICATION	CAUSE (Disesse or Injury that initiated events resulting in death) LAST	OR AS A CONSEQUENCE OF):	
	d		
	PART II. Other significant conditions contributing to a	deeth but not reculting in the underlying cause given in	PERFORMED? AMAILABLE PRIOR TO
MEDIC			1 YES 2 NO OF DEATH!
N.	DID TOBACCO USE CONTRIBUTE TO CAL		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO HOSPITAL: 1 Vinpatient 2	28. PLACE OF DEATH (Check only one) OTHER: ER/Outpatient 3 □ DOA 4 □ Nursing Home 5 □ Residence	
РНҮ	27. MANNER OF DEATH 28a. DATE OF I	NJURY 28b. TIME OF 28c. INJURY AT	8 Uniter (Specify) 28d. DE\$CRIBE HOW INJURY OCCURED
B⊀	Natural 5 Pending 2/3	195 M 1 □ YES 2 X NO	Motor Value Accident
TED	3 Suicide 8 Could not be building, a determined	INJURY — At home, term, street, factory, office rtc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
APLET		my knowledge, death occurred at the time, data and place, and due	
COMPL	29b. SGNATURE AND TITLE OF CERTIFIER		time, date and place, and due to the ceuse(s) end manner as stated.
) BE	ASST Doort h	edind Drames OCH	ABER 29d. DATE SIGNED (Month, Day, Year)
임	30. NAME AND ADDRESS OF PURSON WAS COMPLETED CAUSE	A	
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR	19236 MEAROW U	was Dr Hoostounus
		Reveally	



TO THE HOSPID OR CENTIONS PROSICION: The TO THE FUNEDA CHECKIN The centificate be filed within 72, one that death of the State

NG PRISTANT. The law requires that the death certificate be executed within-ser fours after death. Page 6 may be retained by the hospital or attending physician.

The law certificate has been some by the amending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be man been some man whereal hygiene prior to burial, cremation, or removal.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Lest)							2. DATE OF DEATH D	NY.	YEAR	3. TIME OF DEATN
	MARY	(GRIFFIN					FEB. 1		95	M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH		7 9	IPLACE (State or Foreign
	212 5/ 01/0	1 M 2 F	0.4	YRS.	ONTHS DAYS	HOURS	MIN.	(Month, Day, Year) DEC. 29.		Counti	γ)
1		213-34-0146 96									H CAROLINA
l ~	99. PACILITY NAME (If not institution, give st	9e. FACILITY NAME (If not institution, give street and number)					ON OF DE	ATN	9c. COU	NTY OF D	EATN
6	2315 W. LEXINGTO	_	BA	LTIMO	RE		1				
15		RESIDENCE OF DECEDENT									
DIRECTOR	10a. STATE 10b. COUNTY	í		10c. CITY,	TOWN OR LOCA	TION					10d. INSIDE CITY
	MARYLAND				BA	LTIMO	RE C	CITY			1- YES 2 NO
-	10e. STREET AND NUMBER				10	f. ZIP CODE			10a, CITI	ZEN OF V	WHAT COUNTRY?
ERAL	2315 W. LEXINGTON	CTDEET					1223	1	- 11		And a local control of the second
빌										USA.	
FUNI	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT FORCES? 1	YES 2 XN	MED O	13. WAS DEC	CENDENT O	F HISPAN	IC ORIGIN? (Specify Year, Puerto Ricen, etc.)	or No-	14. RACE	— Americen Indian, k, White, atc.
B	3 K Widowed 4 Divorced	IF YES, OIVE WA				S NO			- 1	Speci	
	3 KJ wygoneg 4 Districted	<u> </u>								BLA	CK
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<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Hila	Do NOT use	retired.)	ost or working	g	1,00			
립	11th GRADE			AE'M A K E	R/HOSP	ттат	MUUT	ER OWN HO	ME		
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-		TINZEGARI				7.1		ME (First, Middle, Malden			
E H	HARRY W.	HYMAN					NCY		ANTH		
1	19e. INFORMANT'S NAME (Type/Print)							loute Number, City or Tow			
2 F	RUBY HAN	NKINS	23	315 W.	LEXIN	GTON	STRE	ET, BALTI	MORE,	MD.	21223
8	204 METHOD OF DISPOSITION	-			DISPOSITION (N				CATION —		
2	1 N Buriel 2 Cremation 3 Remo	ovel from State	cemetery, crer	netory or othe	r place)						
E	The second second		1 WESTE	ERN ST	AR CEM		_		CONSV	ILLE	, MARYLAND
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examiner must be notified TO BE	M WA ()		14-		JUSE.	PH H.	BRU	WN JR. FUI	VERAL	HOM	E, P.A.
			M		1913	w. B	ALII	MURE ST.,	BALT	TMOR	E, MD.21223
medical	ahock, or heart failure. I	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line.									
Ē	IMMEDIATE CAUSE (Finel	1	o on dubit line.		A	7 3					Interval Between Onset and Death
2	disease or condition	Hita	20100	Joan	Lal	1.0	1100	Derellar	1-1	100	1 1 1 1 1
event,	resulting in death)	DUE TO (OR AS A CONSEO	LIENCE DE	The	CA C	CO V	CHUNDA		0/10	of these
		,-									
or other traumatic	Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF):										
E E	If any, leading to immediate cause. Enter UNDERLYING										
를 일		4									
	CAUSE (Disease or Injury C. Due TO (OR AS A CONSEQUENCE OF):										
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2 E	that initiated events	1									į
ĕ ö	that initiated events resulting in death) LAST	d									
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OICAL CE	that initiated events resulting in death) LAST	d	death but not re	esulting in	the underlyin	g ceuse g	iven in I	Part I. 24a. WAS AN PERFOR	MED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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		2, 3 should
		Pages 1,
		permit.
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215-00	attending	e as the
BALTIMORE, MARYLAND 21215-0020	ter death. Page 6 may be retained by the hospital or attending physician.	the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
MARYL	etained by t	should be
AORE, I	te 6 may be r	irector, page 5
ALTIN	death. Pag	funeral di
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DIVISION OF VITAL RECORDS, P.O. BOX 68760, OR ALE THE PHESCIAN: The law requires that the death certificate be executed with

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

212	ai or a	for us	
BALTIMORE, MARYLAND 212	TO THE HOSPITAL OF ALL PRING PHISCIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or a	TO THE FUNERAL WHENTOR After the sentificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us be fled within 72 now and the State Dect. of Health and Mental Horiene prior to burial, cremation, or removal.	C.B.
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	8	2	Te.
	SPITA	NERA Nin 72	N. H
	유	IE FUI	HTA!
1	10 1	TO THE FUNERAL WHICHOR After this centificate has been signed by the attending physician and completely filled in by the be fleet within 72 to be a completely filled in by the State Debt, of Health and Mental Hydiene prior to burial, creamaily or removal.	IMPORTANT: If Item 28 18 marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
1			

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AN CERTIFICATE OF DEATH	D MENTAL HYGIENE REG. NO.	
1. OECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATN 3. TIME OF DEATN	
Horbert Harper	MONTH DAY YEAR	м
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs, last birthday) F UNDER 1 YEAR F UNDER 24 HR	The state of the s	gn
214-44-1544 XM 2 0 F 49 YRS. WATER DATE HOUSES WITH	422 45 MARYIANT	
9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF	F DEATH 9c. COUNTY OF DEATN	
Seten Hill Manor (SCU) BALTIMOR	LF.	
RESIDENCE OF DECEDENT 10g STATE 10b. COUNTY 10g. CITY, TOWN OR LOCATION	10d, INSIDE CITY	
Maryland Baltimore	LUNTES?	
100. STREET AND NUMBER	10g. CITIZEN OF WHAT COUNTRY?	,
626 N Brice St 12121	7 115A	
11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED 13. WAS DECEMBENT OF HIS	PANIC ORIGIN? (Specify Yes or No. 14. RACE - American Indian,	
1 M Never Married 2 Merried FORCES? 1 ✓ YES 2 NO If yes, specify Culter, Me IF YES, GIVE WAR OR DATES 1 YES 2 NO Sp	xican, Puerto Ricen, atc.) Black, White, atc.	
3 Widowed 4 Divorced	Hro-Ame	r.
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working	16b. KIND OF BUSINESS/INDUSTRY	
Elementary/Secondary (0-12) College (1-4 or 5+)	Callaga	
o I o Indinfamance	Lonege	
17. FATNER'S NAME (First, Middle, Last)	NAME (First, Middle, Maiden Sumerne)	
190. INFORMANT'S NAME (Type/Print)	THE STUDIOS	
William Haragia 4012 D.V.	Iral Route Number, City or Town, State, Zip Code)	20
209. METHOD OF DISPOSITION 200. METHOD OF DISPOSITION 200. PLACE AND DATE OF DISPOSITION (Name of	Na. Dalloilla. Aldo	$\langle 1 \rangle$
20b. PLACE AND DATE OF DISPOSITION 1 Buriel 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify)	+ 2/3/190 R H O Town, State	
Gai 130/1 Dies	FACILITY DOI O: CO. MO.	1
Joseph L	Kuss tuneral Hami	2
1222 W.	North Ave. Balto, Md.212	46
23. PART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, a shock, or heart failure. List only one cause on each line.	such as cardiac or reapiratory arreat, Approximate Interval Batw	
IMMEDIATE CAUSE (Final	Onsat and D	
disease or condition	IENCY SYNDROME	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions,		
If any, leading to immediata cause. Enter UNDERLYING		
CAUSE (Disease or Injury		
that initiated events resulting in death) LAST	İ	
4		
PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given	In Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDS	NGS
	1 YES 2 NO COMPLETION OF CAUS	SE
	1 _ YES 2 _ NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO 🗷 UNCERT	AIN 🗆	
25. WAS CASE REFERREO TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:		
1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Resident	ce 6 Other (Specify)	
27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK?	28d. OEŞCRIBE HOW INJURY OCCURED	
2 Accident Investigation Investigation		
3 Suicida 8 Could not be determined determined 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, etc. (Specify)	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29e. CERTIFIER (Check only 1) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end		
one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at	the time, date end place, end due to the cause(s) end manner as state	d.
29b. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE	NUMBER 29d. DATE SIGNED (Month, Day, Year)	
Manighten D29	907 > 2.14.95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. KRISHVAN, M. 821 N. E.J. 7AW S7 #-3	OS BALTIMORE MD 21201	
KICKISHNAN, MU 821 N. EJ (AW 57 #- S	3 MANIMUM MODE	

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30. NAME AND ADDRESS OF

31. DAKE FILED (Month, Day,

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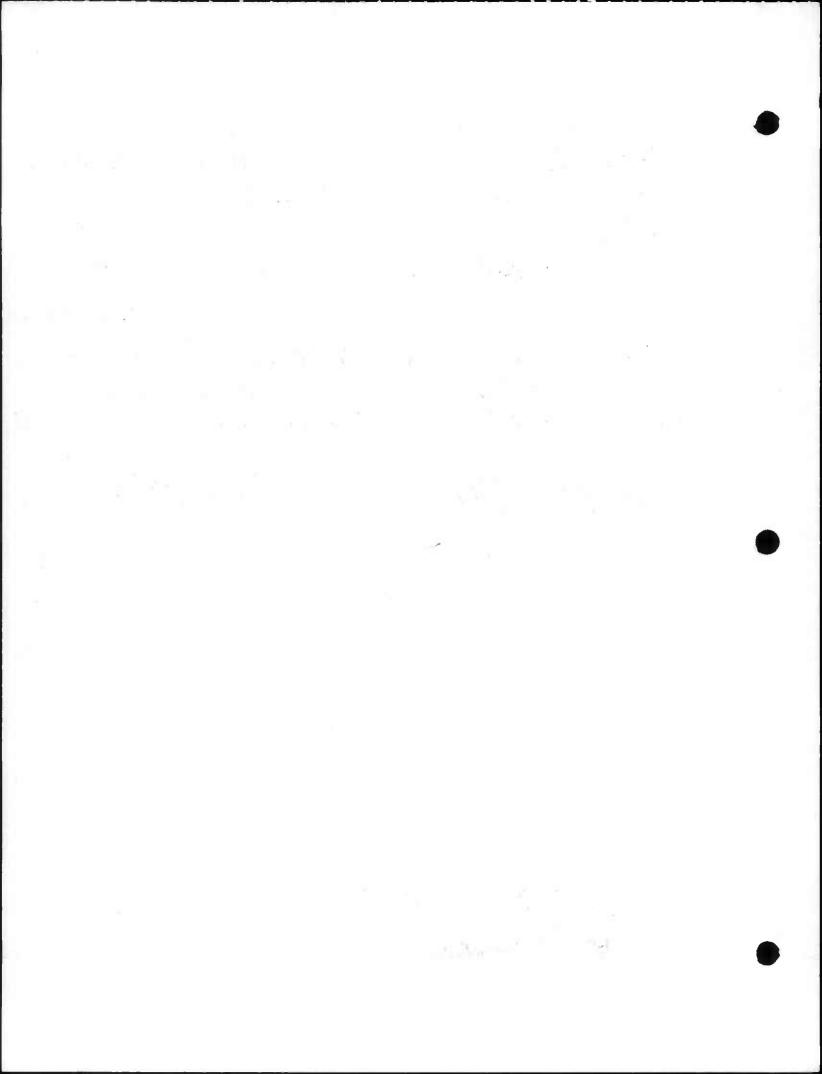
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	at the	by th	and k
	res th	signed	Attach
	redu	been sig	H PO
	e law	has t	Dant
	AN: T	ificate	State
	WSICI)	s cert	in the state that the State Dent of Health and Mental Hunjane prior to burial cremation or removal
	HE DE	E	attilluc
	1	東京	Ser ch
	F	RECT	4
	P. S.	No No	2
	5.	15	1

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH 93 4. SOCIAL SECURITY NUMBER (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign DAYS HOURS 1 M 2 F MIN. YRS. dno 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR MOTE STATE 10b. COUNTY 10d. INSIDE CITY more 1 YES 2 NO 100. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 20 MAS DECEDENT EVER IN U.S. ARMI FORCES? 1 YES 2 NO 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Caben, Mexican, Puerto Rican, atc.)
1 YES 2 NO Specify: 14. RACE — American Indian Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 Wildowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTR ve kind of work done Do NOT use retired.) College (1-4 or 5+) minist d 17. FATHER'S NAME (First, Middle, Last) 255 notified at BE INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street 2 0 be 20e. METHOD OF DISPOSITION
1 Burlal 2 Cremellon 3 Removal from State 20b. PLATE AND DATE OF DISPOSITION (Name of must 4 Donalion 5 Other (Specify) examiner 22. NAME AND ADDRESS OF FACILITY TO SEDE L. RUS 21. SIGNATURE OF FUNERAL SERVICE LICENSEE tome medical 23. PAIN I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or reapiratory arrest, shock, or heart feliure. List only one ceuse on each line. Approximata interval Between **IMMEDIATE CAUSE (Fine)** Onset and Death the diseese or condition THE H (Themen event, reaulting in death) traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING 0 CAUSE (Disease Dr injury DUE TO (OR AS A CONSPQUENCE OF): that initiated events requiting in death) LAST Injury, or PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE any 1 TYES 2 T NO Shows OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL OTHER: 1 YES 2 NO □ Inpetient 2 □ ER/Oulpetient 3 □ DOA 4 Nursing Home Sp Basidence 6 Other (Specify) marked, or 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO á investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28I. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) The state of 8 Could not be determined COMPLETED 4 Homicide 29a CERTIFIER CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPID TO THE FUNERA De filed within IMPORTANT 296. SKINATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Qay, Year) BE 9 8 2 NU

ETED CAUSE OF DEATH (ITE) 27) (Type, Print)

120

16



BALLIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ith the State Dept. of Realth and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, F.O. BOX 66/160	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withher hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept, of Heatth and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

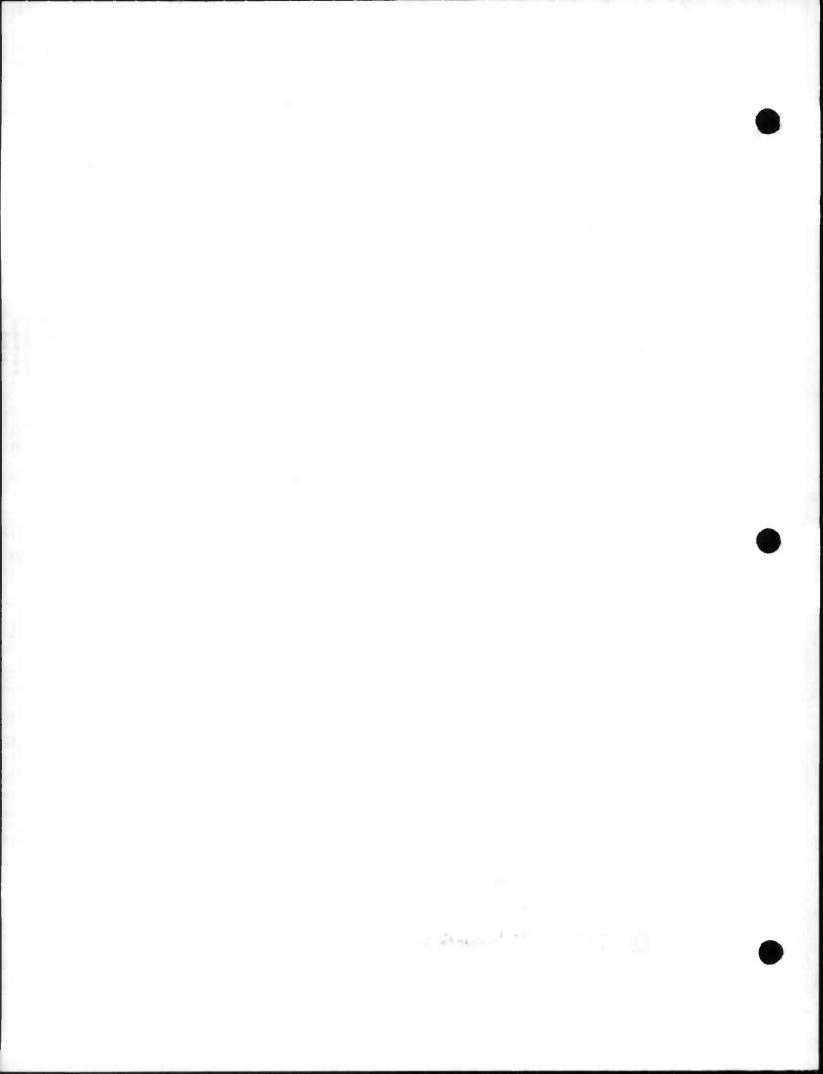
Or. John J. LC 31. DATE FILED (Month, Day, Year) FEB 1. 7. 1995

LOh

517A St. 82. REGISTRAS'S SIGNATURE

Stemmers Run

)	J	04717
	1 - FOR STATE REGISTRAR	STATE OF N	MARYLAND /	DEPAR	RTMENT	OF H	EALTH DEAT	AND I	MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE	OF DEATH			3. TIME OF DEATH
	Estella	Horne	er						Feb			YEAR Q.5	2:25am M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER 1	YEAR	IF UNDER	24 HRS.	7 DATE	OE BIRTH		e punti	HPLACE (State or Foreign
	216-10-7587	1 M 2 💢 F	85	YRS.	MONTHS	DAYS	HOURS	MIN.	Sex	t.19	,190	9 Count	PA.
1	Se. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY,	TOWN C	R LOCATIO	N OF DE			_	UNTY OF E	A-4A-7
DIRECTOR	Riverview Nur	sing Ce	entre			F	Esse	x			Ba	lti	more
JE I	10a. STATE 10b. COUNTY	-		10c. CIT	Y, TOWN OF	R LOCAT	ION						10d. INSIDE CITY
	Md.	BAlt	imore				•	Ess	ex				LIMITS? 1 YES 2 NO
AL.	10e. STREET AND NUMBER					101.	ZIP CODE				10g. CI	TIZEN OF	WHAT COUNTRY?
H	1 Eastern Av	re.						21	221			USA	
FUNERAL	11. MARITAL STATUS	12 WAS DECEDEN	TEVER IN U.S. ARI	MED	13. W	AS DEC	ENDENT OF	F HISPAN	NIC ORIGIN	? (Specify Yes	or No-	14. RAC	E — American Indian.
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W	YES 2 N	0	- 11	yes, spe	2 NO	, Maxica	in, Puerto F	Rican, etc.)		Spec	k, White, etc. hity:
8	15. DECEDENT'S EDUC		16a. DEC	CEDENT'S	USUAL OC	CUPATIO	IN .		16b.	KIND OF BUS	SINESS/IN	DUSTRY	White
ᇤ	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +	(Gir	ve kind of Do NOT u	work done du se retired.)	uring mo:	st of working	7					4.00
립	7t.h			pai	rs					ontir	nant	a 1	Can
COMPLET	17. FATHER'S NAME (First, Middle, Last)		1 2.0	, pa I	10		18. MOTH	ER'S NA		Aiddle, Maiden		al	can
ш	Fred Deshne	r						Co		McG1		lin	
8	19a. INFORMANT'S NAME (Type/Print)		19b	MAILING	AOORESS	(Street at	nd Number	or Rural I		er, City or Town	-		
2	Ethel Diehl												21220
1	20s. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Remo		20b. PLACEA	ND DATE	OF DISPOSIT				OATI			City or To	
	4 Donation 5 Other (Specify)	val from State	Cemetery, cren			0+0		2/1	71/05	D 7 1	1 4 4 4	ore	MD
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE ()	Parkw	900	22. N	AME AN	O ADDRES	S OF FA	CILITY	BA		IOLE	MID.
1 1	P TIMA	1/0		4	C	onr	ell	y F	uner	al Ho	ome	of	Essex
-	23. PART i. Enter the diseases, or co	10n	nell	4	_	~ ~	2.0						
	ahock, or heart (ailure. I	ist only one cau	aa on aach ilm	m. 00	anter t	he mod	da of dyir	ng, suci	h es card	lac or respi	ratory er	rest,	Approximata Interval Between
	IMMEDIATE CAUSE (Final disease or condition	1		Į.									Onset and Daath
	resulting In death)	DEHYDRA											JAN. 199
		DUE TO	(OR AS A CONSEO	UENCE O	F):								
8	Sequentially list conditions, Due to (or as a consequence of):												
CERTIFICATION	If sny, leeding to immediate cause. Entar UNDERLYING	DOE 10 (OH AS A CONSEC	UENCE O	F):								
윤	CAUSE (Disease or injury that initiated events	OUF TO	OR AS A CONSEO	LIENCE O	n.								
틽	resulting in death) LAST				,								i i
S													-
AL AL	PART ii. Other significant conditions				in the und	larlying	cause gl	lven in	Part i.	24a. WAS AN		24b	WERE AUTOPSY FINDINGS
2	DEGENERATIVE	OSTEDA	BIHBIT	IS						1 TYES			AMILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL	OSTEOPOROSIS								1				OF DEATH? 1 YES 2 NO
	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEAT	H YE	S 🗆 N	0 🗆	UNCE	RTAIN	V 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE	OF DEA	TH (Check on								
Si	1 YES 2 NO	HOSPITAL: 1 Inpatient 2	ER/Outpatient 3	□ DOA	OTHER:		5 🗆 Rea	ldence	6 🗆 Other	(Specify)			
	27. MANNER OF DEATH	26a. DATE OF (Month, Da		26b. TIM		26c. INJU	JRY AT			CRIBE HOW IN	JURY OC	CURED	
ВУ	Pending Accident Investigation	(Working Da	ly, real/	1140	M		ES 2	NO					
	3 Suicide 6 Could not be	26s. PLACE OF	INJURY — At horr	ne, farm, :	street, fector	ry, office			28f. LOCA	TION (Street a	nd Numbe	r or Rural F	Route Number,
TE	4 Homicide determined	ounding, t	(opoury)						City o	r Town, State)			
7	29a. CERTIFIER (Check only CERTIFYING PHYSIC	IAN: To the best of	my knowledge des	th occum	ed at the tim	no deta	and place	and due	to the cour	20(2) 201			
COMPLETED	(Check only one) 2 MEDICAL EXAMINER												and manner or stated
. 11	29b. SIGNATURE AND TITLE OF CERTIFIER	A 4	10.5		,y spi	1				and piece, and		-	
BE	THE OF CHILDRE	LIGHT	ba				29c. LICEN	VSE NUM	ABER / ? /	(6)	284. DAT	E SIGNES	(Marin, Day, Mary
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAMP	E OF DEATH (ITEM	27) /hm=	Print)		-	6	7)-	/ / /	>	7	1195
	The state of the s	L. P. Cars	- or AEVILL (IIEM	eri (Abe	rinit)								55.00



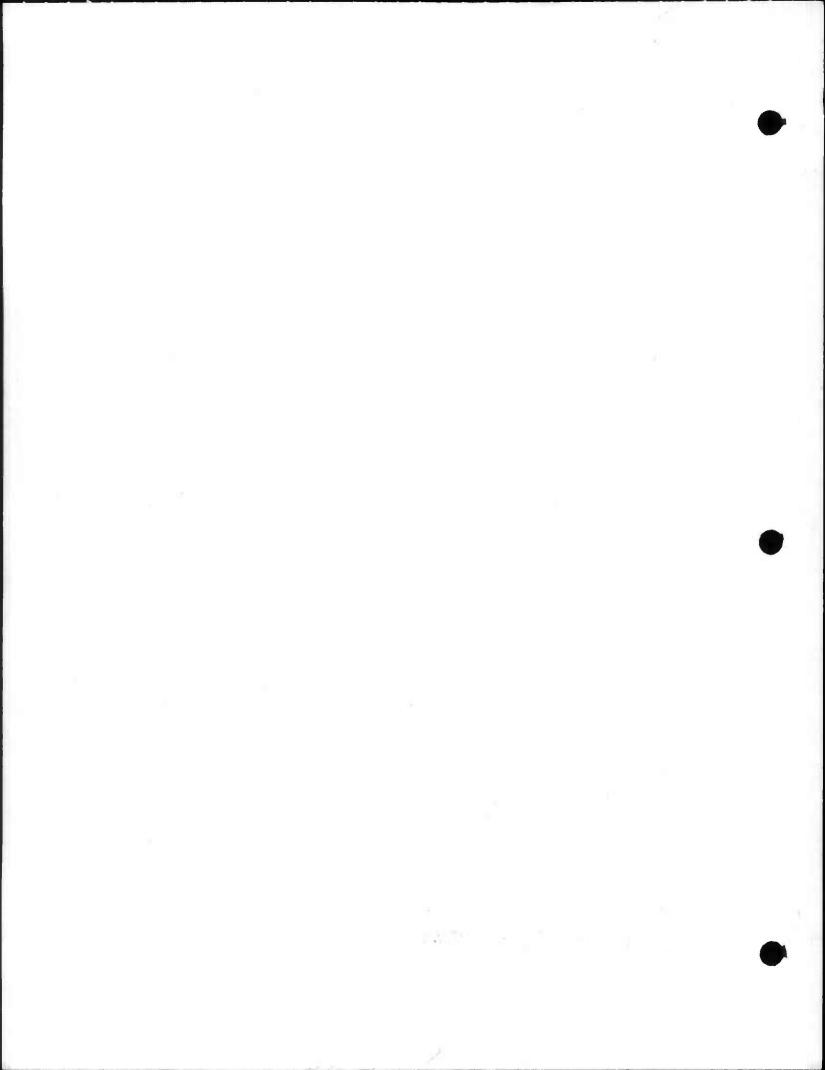
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the h TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once		PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Panes 1, 2, 3 should	n 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremaration, or removal.	APORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTA	L HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI CERTIFIC			MENTAL HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last) SAMUEL ROE	BERT HANG	CE SR.			2. DATE OF DEATH MONTH DA				
		M M 2 □ E		MONTHS DAYS HOUSE AMM (Month, Day, Year)				5 0532A M IRTHPLACE (State or Foreign punity) Arryland		
H.	90. FACILITY NAME (if not institution, give street 1726 DARLEY AVE	DE DEATH								
DIRECTOR	RESIDENCE OF DECEDENT									
E	10e. STATE 10b. COUNTY	_		TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?		
	MD N/2 100. STREET AND NUMBER	4	Ba.	ltimore	ZIP CODE		40- OTTOTAL	1 X YES 2 NO		
FUNERAL	1726 Darley Avenue	e		10.00	21213		U.S.			
5	11. MARITAL STATUS 1	2. WAS DECEOENT EVER IN U	U.S. ARMED			IC ORIGIN? (Specify Yes	or No.— 14, R	ACE American Indian.		
ВУ Б	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES	2 LNO ES		city Cuban, Mexican 2 NO Specify:	i, Puerto Ricen, etc.)		Black, White, etc.		
	15. DECEDENT'S EDUCAT	TION I						Black		
	(Specify only highest grade co	mpleted)	(Give kind of world life. Do NOT use n	k done during mos	N I of working	16b. KIND OF BUS	INESS/INDUSTR	Υ		
집		College (1-4 or 5+)	Truck I	Driver		Liquid	Car Bon	nic		
COMPLETED	17, FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAM	AE (First, Middle, Meiden				
BE (Kelly J. Hance				Evelyr	n M. Tates				
0	19e. INFORMANT'S NAME (Type/Print)					oute Number, City or Town				
	Charles B. Hance					altimore,	Marylan	nd 21202		
	20e, METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remova	If from State camet	PLACE AND DATE OF I	r placa)		1	CATION — City o			
	4 Donation 5 Other (Specify)	Gar ISEE	rison Fo		Cem.		ngs Mil	ls, MD		
	· Vanlor	1 TAX		March	Funeral E. North	Home East Avenue/Ba	ltimore	, MD 21202		
	23. PART I. Enter the diseases, or con shock, or heart fallure. Lis	nplications that caused t	the death. Do not	anter the mod	de of dying, auch	as cardiac or respin	retory arrest,	Approximata		
	IMMEDIATE CAUSE (Final	Atherosch		ardio	vas cula	r d3	euse	Interval Between Onset and Death		
2	DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A C	ONSEQUENCE OF):							
FIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A C	ONSEQUENCE OF):							
E	resulting in death) LAST									
23 H	d.									
	d							1		
AL	PART II. Other algnificant conditions of Diwhers M	contributing to death but	not reculting in t	tha underlying	ceuse given in F	Pert I. 24s. WAS AN / PERFORI	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
AL	PART II. Other algnificant conditions of	ellitus.				PERFORI	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
AL	PART II. Other algnificant conditions of	BUTE TO CAUSE OF	DEATH YES	□ NO □		PERFORI	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
AL	PART II. Other algnificant conditions of the part of t	BUTE TO CAUSE OF	DEATH YES	O NO (Check only one)	UNCERTAIN	PERFORI	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
AL	PART II. Other algnificant conditions of the part of t	BUTE TO CAUSE OF 28 OSPITAL: Inpetient 2 ER/Outpatt	DEATH YES DEATH (STATE OF DEA	Check only one) NO	UNCERTAIN 5XX Mesidence 6 IRY AT	PERFORI	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X X ES 2 NO 27. MANNER OF DEATH 1 Metural 5 Pending	BUTE TO CAUSE OF 26 IOSPITAL: Inpetient 2 ER/Outpatt	DEATH YES	NO (Check only one)	UNCERTAIN 5XX Mesidence 6 IRY AT	PERFORI	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X X ES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	BUTE TO CAUSE OF 28 OSPITAL: Inpetient 2 ER/Outpatt	DEATH YES DEATH YES DEATH (South 1	(Check only one) OTHER: Nursing Home Y M 1 Y	UNCERTAIN SX Xesidence 6 JRY AT 1K? ES 2 \(\sum NO \)	PERFORI	MED?	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
BY PHYSICIAN: MEDICAL	PART II. Other algnificant conditions of the part of t	BUTE TO CAUSE OF 26 COSPITAL: Inpetient 2 = ER/Outpate 28e. DATE OF INJURY - building, etc. (Specify IN: To the beet of my knowled	DEATH YES PLACE OF DEATH (Jent 3 DOA 4 28b. TIME 0 INJUR At home, ferm, streen	(Check only one) OTHER: Nursing Home Nursing Home Y M 1	UNCERTAIN SXX Mesidence 6 SXX Mesidence 6 SXX Property AT RK? ES 2 NO	PERFORI 1 YES 2 Other (Specify) 28d. DESCRIBE HOW IN City or Town, State)	MED? JURY OCCURED Ind Number or Rui	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
BY PHYSICIAN: MEDICAL	PART II. Other algnificant conditions of the part of t	BUTE TO CAUSE OF 26 COSPITAL: Inpetient 2 = ER/Outpate 28e. DATE OF INJURY - building, etc. (Specify IN: To the beet of my knowled	DEATH YES PLACE OF DEATH (Jent 3 DOA 4 28b. TIME 0 INJUR At home, ferm, streen	(Check only one) OTHER: Nursing Home Nursing Home Y M 1	UNCERTAIN SXX Mesidence 6 SXX Mesidence 6 SXX Property AT RK? ES 2 NO	PERFORI 1 YES 2 Other (Specify) 28d. DESCRIBE HOW IN City or Town, State)	MED? JURY OCCURED Ind Number or Rui	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
BE COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other algnificant conditions of the part of t	BUTE TO CAUSE OF 26 COSPITAL: Inpetient 2 ER/Outpati 28e. DATE OF INJURY (Morith, Dey, Year) 28e. PLACE OF INJURY = building, etc. (Specify) IN: To the best of my knowled on the basis of examination a	DEATH YES DEATH YES DEATH (Dent 3 DOA (128b. TIME 0 INJUR At home, ferm, streen At home, ferm, streen dige, death occurred a send/or investigation, is	(Check only one) ITHER: Nursing Home Pr M 28c. INUL WOP 1	UNCERTAIN SXX Mesidence 6 SXX Mesidence 6 SXX Property AT RK? ES 2 NO	PERFORI 1 YES 2 3 Other (Specify) 28d. DESCRIBE HOW IN 28f. LOCATION (Street a: City or Town, State) to the cause(e) end menuime, date end place, end BER	MED? NO NURY OCCURED and Number or Rul ner ee stated.	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO ral Route Number, se(e) end manner ee stated. NED (Month, Day, Year)		
COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other algnificant conditions of the part of t	BUTE TO CAUSE OF 26 COSPITAL: Inpetient 2 ER/Outpett 28e. DATE OF INJURY (Morth, Dey, Year) 28e. PLACE OF INJURY building, etc. (Specify IN: To the best of my knowled On the basis of examination of	DEATH YES DEATH YES DEATH (Dent 3 DOA (29b. TIME 0 INJURY At home, ferm, streen dige, death occurred as and/or investigation, i	(Check only one) ITHER: Nursing Home Nursing Home SF Y M 28c. INJU WOF 1	UNCERTAIN SX Residence 6 JRY AT 1K? ES 2 NO and plece, end due to the till occurred at the till 29c. LICENSE NUMB O . C . M	PERFORI 1 YES 2 3 Other (Specify) 28d. DESCRIBE HOW IN 28f. LOCATION (Street a: City or Town, State) to the cause(e) end menuime, date end place, end BER	MED? AJURY OCCURED and Number or Rul and due to the ceur 29d. DATE SIGN F.E.I.	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO rel Route Number, se(e) end manner ee stated. HED (Month, Day, Year) B . 13/95		



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	an.	effely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should
BALTIMORE, MARYLAND 21215-0020	thing, hours after death. Page 6 may be retained by the hospital or attending physician.	bunal -1
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF H	EALTH AND		HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	DEATH		3. TIME OF DEA	TH
	RENE	HITCHENS			FEBRU	JARY 10,	1995	12:55	рм	
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (-	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF (Month, D			PLACE (State or Fo	oreign
	215-16-3115	1 M 2 PF	ONTHS DAYS	HOURS MIN.		24-64	Countr	21		
	9a. FACILITY NAME (If not institution, give at		9	b. CITY, TOWN OF	R LOCATION OF DI	EATH	9c. CO	UNTY OF D	EATH	
DIRECTOR	THE JOHNS HOPKII	NS HOSPITAL		BALTIMO	ORE CIT	Y				
띮	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		ine CITY	TOWN OR LOCATION	ON				44.4.1114.114.4.1	
8	mel			BAHN	/				10d. INSIDE CITY	
	10e. STREET AND NUMBER			101	ZIP CODE		100 0	TIZEN OF W	HAT COUNTRY?	NO
FUNERAL	1636 Abbots	t. 1 61			2/2	19	log. G	7	MAI COUNTRY?	
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DECE	NDENT OF HISPAI	NIC ORIGIN?	Specify Yes or No-	14 BACE	- American Indi	00
	1 Never Married 2 Married	FORCES? 1 YES		If yes, spec	cify Cuban, Maxica	in, Puerto Rice	in, etc.)	Black Speci	, White, etc.	,
ВУ	3 ☐ Widowed 4 ☐ Divorced				7	,			TAON	5
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	18e. DECEDENT'S US	k done during most	N t of working	16b. Ki	ND OF BUSINESS/II	DUSTRY		
4	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use r	retired.)						
Z			uner.	aflan	d					
	17. FATHER'S NAME (First, Middle, Last)	11.41.00		/ /	18. MOTHER'S NA	ME (First, Mide	dle, Maiden Surname)			
BE	19a. INFORMANT'S NAME (Type/Print)	titchens			11016	7/	tull			
2	Thank (lypeg-init)	1. t. hear	196. MAILING AL	DDRESS (Street and	d Number or Rural	Route Number,	City or Town, State, 2	ip Code)	2/2/	8
	20e. METHOD OF DISPOSITION	Tenens	1630	6 1700	01570	1 3/	BIA	TIM	11	
	1 Donation 8 Other (Specify)		PLACE AND DATE OF I		ne of	DATE	20c. LOCATION -	- City or To	wn, Slata	
	21. SIGNATURE OF FUNERAL SERVICE LIC		cumpuy		D ADDRESS OF FA	CILITY J	1381	10.11	nd.	_
	Qut	1 4		Bett	Fyn	enti	1 1400	u	2/5,	15
	Jarren	Bells		1/2	N.CA.	Kolin	0 55.	150%	w. ne	Z
	23. PART i. Enter the diseases, or coshock, or heart feliure. I	omplications that caused List only one cause on a	the death. Do not sch line.	enter the mod	e of dying, suc	h ss cerdisc	or respiratory s	rrest,	Approxim interval B	
	IMMEDIATE CAUSE (Fine)								Onset and	
	disease or condition								2 40	eks
		DUE TO (OR AS A	CONSEQUENCE OF):							13
ON	Sequentially list conditions,	ALL OUE TO JOB AS A	CONSEQUENCE OF):							
TA.	If any, leading to immediate cause. Enter UNDERLYING	OUE TO (ON AS A	CONSEQUENCE OF):							
CERTIFICATION	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):									
F	resulting in death) LAST	RETROV	RAL IN	Crand					Syen	J3
	DART II OIL - I - III - III			141 11 11					1	
AL	PART II. Other significent conditions	contributing to deeth be	it not resulting in	the underlying	ceuse given in	Part i. 24	PERFORMED?	246.	WERE AUTOPSY FI	
ă						1	YES 2 NO	100	COMPLETION OF CO	CAUSE
Σ							•		1 TES 2 1	NO
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR				UNCERTAIN	N				
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	(Check only one)						
X	1 YES 2 NO 27. MANNER OF DEATH	1 Inpetient 2 ER/Outpe	Itlant 3 DOA 4	☐ Nursing Home	5 - Residence	8 Other (S)	pecify)			
	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME C	Y WOR	K?	28d. OEŞCRI	IBE HOW INJURY OF	CURED		381
BY	2 Accident Investigation	28- DI ACE OF IN HIDY			S 2 NO					
E I	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Speci	— At nome, term, stre	et, factory, offica		28f. LOCATIO	ON (Street and Number lown, State)	or Aurel A	oute Number,	
COMPLETED	29e. CERTIFIER									
MP	(Check only	CIAN: To the best of my knowle								
8		R: On the basis of examination	and/or investigation,	in my opinion, des	ith occured at the	lime, data end	d place, and due to	he cause(s)	and manner as a	teted.
B	29b. SIONATURE AND TITLE OF CERTIFIER	11.	Diede 1		29c. LICENSE NUN		29d. DA	TE SIGNED	(Month, Day, Year)	
5	MICHAEL FELICER		EDICAL A		L9(228		2/10	195	
	30. NAME AND ADDRESS OF PERSON WHO				1	1 4		2 .	4.	
	MICHAEL FELICER, 1 31. DATE FILED (Month, Day, Year)		ITN'S HOPKINS	de drois	11,600	N. WO	LIFE ST ,	DALTI	NONE MP	11209
	FFR 1: 7 1005	22. REDISTRAR'S SIGNA	TURE							
	1 50 7 1 833	David in manging	and trail.							

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	The state of the s
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR 215-82-1239 35 7/2671959 1 M 2 X F Balto., permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Levindale Geriatric Hospital Baltimore RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1 XYES 2 NO 10e. STREET AND NUMBER FUNERAL 10f ZIP COOF 10g. CITIZEN OF WHAT COUNTRY? 5017 Cordelia Avenue detached for use as the burial-transit 21215 USA Page 6 may be retained by the hospital or attending physician 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried Specify Black IF YES, GIVE WAR OR DATES В 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Nursing Home Elementary/Secondary (0-12) Nursing Assistant 12th 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Leslie Harvey Dorothy Calloway 8 BE funeral director, page 5 should notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Dorothy Williams 5017 Cordelia Avenue Balto., Md. 21215 pe 20e. METHOD OF DISPOSITION

1 X Buriel 2 Cremation 3 Rem

4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must oval Irom State Western Star Cemetery2/20 Catonsville, Md. examiner 21. SIGNATURE O FUNERAL SERVICE LICENSE LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207 completely filled in by the ar the diseases Dr complications that caused the des ck, Dr heart silure. List Dnly one cause or each line. medical 23. PART . Fifter the disease whick, or heart and the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Interval Between 0 IMMEDIATE CAUSE (Final Onset and Daath the cremation, disease Dr condition sepsis resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF). and con o burial, d Stag 1 traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 if any, leading to immediate physician prior cause. Enter UNDERLYING CAUSE (Disease Dr Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events attending resulting in death) LAST 0 the atten Mental I Injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? and of any signed Heafth a 1 | YES 2 | NO t. of F DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) this certificate hy HOSRITAL: OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, 28d. DESCRIBE NOW INJURY OCCURED 8 Netural 5 Pending 1 YES 2 NO BY death 2 Accident 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Sulcide COMPLETED 8 Could not be DIRECTOR: hours after 4 Nomicide 28 determined 29e. CERTIFIER

(Chack only

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the Ilme, date end place, end due to the ceuse(e) end menner ee attend. FUNERAL Within 72 h 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, data and place, end due to the cause(e) end menner ee stated. TO THE HOSPIT TO THE FUNERA be filed within 7 SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 9 5 29c. LICENSE NUMBER BE Mysuan 044817 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Beliedere aux P. RATANT 24346 32. REGISTRAR'S SIGNATURE 7

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DIVISION OF VITAL RECORDS, P.O. BOX 68769

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S HAME (First, Middle, Last)				2. DATE OF DEATH	DAY YE	3. TIME OF DEATH		
1	I SAAC	To age	JAMES			f3 1995			
	247-16-7562	1 M 2 🗆 F	YRS, last birthday) IF UNDER 1 YEA	8 HOURS MIN.	7. DATE OF BIRTH (Month, Day Year)	23 3	BIRTHPLACE (State or Foreign Country)		
(C)	Se. FACILITY HAME (If not institution, give		1	N OR LOCATION OF DE	ATH	9c. COUNTY	OF DEATH		
ECTOR	2209 E. FEDERAI	STREET	BAL'I	IMORE					
DIREC	19a, STATE 10b, COUHT	Y	100-CLTY, TOWN OR LC	сатіон			10d. IHSIDE CITY LIMITS?		
1	10e. STREET AND NUMBER	1		10f. ZIP CODE		10g. CITIZEN	1 YES 2 □ NO OF WHAT COUHTRY?		
FUNERAL	2209 E.F.	deral =	Greet	2121	3		USA		
15	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 2 YES		DECENDENT OF HISPAN specify Cuben, Mexican		ea or Ho— 14.	RACE — American Indian, Black, White, etc.		
B	3 Wildowed 4 Divorced	A PYES, GIVE WAR OR DAT		ES 2 HO Specify		1	Specify:		
6	15. DECEDENT'S EDU	ICATION	16a. DECEDENT'S USUAL OCCUP	ATIOH	16b, KIND OF 8	USIHESS/IHDUST	2/00		
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work done during life, Do NOT use retired.)	most of working	E SECONOLINA		-		
COMPL			Dork Wox	Kor					
8	17. FATHER'S HAME (First, Middle, Last)	/		18. MOTHER'S HAI	ME (First, Middle, Maide	n Sumame)			
H	19a. INFORMANT'S NAME (Type/Print)	i/		UNK	NOWN				
2	INFORMANT S NAME (NYSAPTINI)	a re	19b. MAILING ADDRESS (Stre	et and Number or Rural R	loute Number, City or To	wn, Stete, Zip Cod	1221813		
	20a, METHOD OF DISPOSITION	200	PLACE AND DATE OF DISPOSITION	Newsol	DATE 20c, L	OCATION - City	1021210		
ΙÍ	1 Burial 2 Cremation 3 Rem 4 Donation 6 Other (Specify)		tery, crematory or other place	ST	122 por 1	Bal-Line	CE MA		
	21. BIOHATURE OF FUNERAL SERVICE LI	CENSEE	22. HAME	AND ADDRESS OF FAC	DILITY CY	10000	Tringral Hame		
	1/200.	1. 6.1		e Derri		in D	1/ 12 2:01		
	23. PART I. Enter the diseases, or	complications that caused	the deeth. Do not enter the	mode of dyling, such	Heights	piratory arrest.	Approximate		
	ehock, or heart feilure. IMMEDIATE CAUSE (Final	Liet only one cause on each	ch line.	0.000	201 (1020)0 1000	, , , , , , , , , , , , , , , , , , , ,	Interval Between Onset and Death		
	disease or condition tesulting in death) 1. ATTOM WENTY COMPOSITION DISEASE								
		DUE TO (OR AS A	CONSEQUENCE OF):		9661				
8	Sequentially list conditions,	h. Due to (On as a	CONSTRUCT OF						
RTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DOE TO (ON AS A C	CONSEGUENCE OF):						
띮	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	COHSEQUENCE OF);				- 		
E	resulting in death) LAST	d							
L CE	PART II. Other significent condition	ns contributing to deeth bu	t not recuiting in the underly	ring ceuse given in I	Part I. 24a. WAS A	N ALITOREY I	24b. WERE AUTOPSY FINDINGS		
CAL	Surzuna Dis			mg codec given in i	PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDIC			-		_ Hors	2 NO	OF DEATH?		
- 2	DID TOBACCO USE CONT	RIBUTE TO CAUSE OF	DEATH YES NO	☐ UNCERTAIN	- HABIDA	Oland	1 YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	2	6. PLACE OF DEATH (Check only o						
YSIC	TYPES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpet	tient 3 DOA 4 Nursing H	ome XIXResidence	8 Other (Specify)				
H	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF 26c.	INJURY AT WORK?	26d. DESCRIBE HOW	INJURY OCCURE	D		
À	2 Accident Investigation			YES 2 NO					
8	3 Suicide 6 Could not be 4 Homicide datermined	building, etc. (Specifi	At home, ferm, street, factory, o	Mica	261. LOCATIOH (Street City or Town, State	and Number or Re	ural Route Number,		
	29a. CERTIFIER								
COMPLETED	(Check only		dge, death occurred at the time, d and/or investigation, in my opinion						
	200 SECONATURE AND TITLE OF CERTIFIE		endor arvenigation, in my opinior						
B	Warner D. a.	The 10.		29c. LICENSE NUM		The second secon	14,1995		
10	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type, Print)	O.C.M.	E.	LEP.	14,1970		
	A / 1	Kopou Mo 1	11 Penn Stre	eet, Balt	imore,	Maryla	nd 21201		
	FEB 1 7 1995	32. REGISTRAR'S SIGNAT	P. C. M						



Pages 1, 2, 3 should permit. funeral director, page 5 should be detached for use as the burial-transit Page 6 may be retained by the hospital or attending physician. hours after death. nding physician and completely filled in by the Hygiene prior to burial, cremation, or removal. the death certificate be executed with attending physician Health and Mental that has b ₩. OR ATTENDING PHYSICIAN: The certificate t with c After death

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

notified 9 must medical examiner the traumatic event, other t 0 been signed by pt. of Health and 3 shows any I 23 0 marked. 99 DIRECTOR: A 58 TO THE HOSPITAL TO THE FUNERAL (De filed within 72 h HOSPITAL

Item# 7.G-film 720 per FH. 2/17/95 P.C STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH FEBRUARY 15,95 **EDWARD** JORDON HIRAM 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 3 77 IF UNDER 1 YEAR | IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign Country) DAYS HOURS 15 M 2 | F 77 YRS. 220-07-4746 MD 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 237 S. MADISON COURT BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE CITY MD YES 2 NO 10e, STREET AND NUMBER FUNERAL 10g, CITIZEN OF WHAT COUNTRY? 21202 237 S. MADISON CT. U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11 MADITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married If yes, specify Cubs
1 ☐ YES 2 NO BY Specify: Specific 3 Widowed 4 Divorced BLACK 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) (0-12) College (1-4 or 5 +) INDUSTRY LABORER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) LEE UNKNOWN JORDON BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 EVELYN JORDON 2038 CLIFTWOOD AVE BALTIMORE, MD 21213 20s. METHOD OF DISPOSITION
1-☐ Burlel 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State GARRISON FOREST VA CEM OWINGS MILLS, MD. 2/21 22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOME 21. SIGNATURE DE FUNERAL RERVICE/DOENSE 1129 N. CAROLINE ST. BALTO, MD21213 23. PART | Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. Liet only one cause on each line. Approximate interval Between IMMEDIATE CAUSE (Fine) **Onset and Death** diseese or condition_ raest resulting in death) CERTIFICATION Sequentially list conditions, QUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate e. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART ii. Other significent conditions contributing to deeth but not reaulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 TES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Home 5 Residence 8 ☐ Other (Specify) 26a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT 26d, DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending M 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, fectory, office building, afc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homfolde 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and dus to the cause(s) and menner as attend. and/or investigation, in my opinion, death occured at the time, date end place, and dus to the cause(s) and manner as stated. 29c. LICENSE NUMBER BE 0 DEATH (ITEM.27) (Type, Print)

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31. DATE FILED (Mogith, Day, Year)

1

1995

32. REGISTRAR'S SIGNATURE

Dender Rules

BALTIMORE, MARYLAND 21215-0020

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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any flower and death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE	0F	MARYLAND	I	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGI	ENE
		C	E	RTIFICATE	0	F DEAT	THE .		DEC	NO

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM	ENT OF H	EALTH AND I	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH 3. TIME OF DEATH					
	James	Johr	nson					95			
Ü	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8.	BIRTHPLACE (State or Foreign			
	247-26-7005	76 YRS. MO	NTHS DAYS	HOURS MIN.	July 28,		Country) S. Carolina	- 1			
	9e. FACILITY NAME (If not institution, give si	reet and number)	96	CITY, TOWN C	R LOCATION OF DE		9c. COUNTY		\neg		
DIRECTOR	Union Memorial Hospital			Baltin	nore		N/A				
RE	10e. STATE 10b. COUNTY			OWN OR LOCAT	ION			10d. INSIDE CITY			
	MD N/	A	Balt	imore				1 VES 2 NO			
3AL	10e. STREET AND NUMBER				ZIP COOE			N OF WHAT COUNTRY?			
FUNERAL	401 Presstman Str			2	1217		U.S	S.A.			
E	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED			NIC ORIGIN? (Specify Yearn, Puerto Rican, atc.)	or No- 14.	. RACE — American Indian, Black, White, atc.			
Β¥	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES A		2 NO Specify			Specify: Black	- 1		
	15. DECEDENT'S EDUC	CATION	16a. DECEDENT'S USU	IAL OCCUPATIO	M	16b. KIND OF BU	SINESS/INDI IS.				
Ш	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during mo	st of working	100. 100.0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
AP.		N/A	Laborer			N/A	1				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Malden	Surname)				
BE (Promise Johnson				Mabelle	cogdell cogdell			- 1		
10	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow			\neg		
-	Annie Stephers		401 Pre	sstman	Street/I	Baltimore,	MD 212	217			
	20e. METHOD OF DISPOSITION 11/2 Burlel 2 D Cremetion 3 Remo	aval from State com	PLACE AND DATE OF D		me of	OATE 20c. LO	CATION — City	or Town, State			
	1 Buriel 2 Cremetion 3 Remo	1110	se Hill Me	em. Gar		2-15 Cor	way, S	5.C.			
	21. SIGNATURE OF JUNERAL SERVICE LIC	ENSEE	//		Funeral	Home East	-				
	JUMUS	N AND	2				altimo	re, MD 21202			
	23. PART i. Enter the diseases, or c	omplications that caused	the deeth. Do not	enter the mo	de of dying, suci	h ea cardiec or respi	ratory errest	, Approximete			
- 1	IMMEDIATE CAUSE (Final	List only one cause on e			0	04/10		interval Betwee			
	disease or condition reaulting in death)	r. /	linde	c Ce	why	Henry					
		OUE TO (OR AS A	CONSEQUENCE OF):		, ,	2					
8	Sequentielly list conditions, Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death										
A	if any, lesding to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):	0							
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E	reaulting in desth) LAST										
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AL	PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY PERFORMED? AMILABLE PRIOR TO										
20						1 _ YES 2		COMPLETION OF CAUSE DF DEATH?	E		
ME								1 TES 2 NO			
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR				UNCERTAIN	V 🗆					
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH (C	theck only the)					\exists		
ΙΥS	1 TYES 2 TO NO 27. MANNED OF DEATH	1 Inpetient 2 ER/Outp	atlent 3 X DOA 4 I	Jursing Home		6 Other (Specify)					
	1 Netural 5 Pending	(Month, Day, Year)	28b. TIME OF INJURY	WO	RK?	28d. DEŞCRIBE HOW II	JURY OCCUR	ED			
B	2 Accident Investigation	28e. PLACE OF INJURY	At home form of		ES 2 NO				_		
COMPLETED	3 Suicide 8 Could not be 4 Homicide determined	building, atc. (Spec	- At nome, farm, stree	i, tectory, office		28t. LOCATION (Street a City or Town, State)	nd Number or F	Rural Route Number,			
9	29e. CERTIFIER			- 157 - 157					-		
MP	(Check only	CIAN: To the best of my knowl									
8		R: On the basis of examination	end/or investigation, in	my opinion, de	ath occured at the	time, date end piece, en	d due to the ce	euse(s) end menner ee stated	•		
BE	296. SIGNATURE AND TITUE OF CERTIFIER	//	1_		29c. LICENSE NUM	IBER /	29d. DATE SI	GNED (Mgnth, Day, Ybar)			
5	20 NAME AND ADDRESS OF BERNEY	ny	17		D003	57	0/1	14/95			
, -	30. NAME AND ADDRESS OF PERSON WHO	A TO S		57.	PAIII	DINDE	Rai	TO 1 1 1 1	Az.		
ļ	31. DATE FILED (Month, Day, Year)	TA DECISTATION CONT		21.	1700	PLACE	OHL	-10. MD 21de	10		
	FEB 1 7 1995	22. REGISTRAR'S SIGNA	C.J. W								
	LED T (1333	July Company	WHEELS.								

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		FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTMENT (CERTIFICATE	OF HEALTH AND OF DEATH		SIENE . NO.		
		1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF OEA	DAY	YEAR 3. TH	IME OF OEATH
		ALVIN 4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In	JETER		FEB			8:03 P
should		579-80-5236 9s. FACILITY NAME (If not institution, give sm	1× M2 DF 30	YRS. MONTHS D	DAYS HOURS MIN.	7. DATE OF BIRTY (Month), Day, Ye	55 1	Penns	E (State or Foreign
2, 3	СТОВ	PRINCE GEORGES			CHEVERL		PRII	NCE G	EORGES
Pages 1,	REC	10a. STATE 10b. COUNTY		10c. CITY, TOWN OR				10d.	INSIDE CITY
permit. Pa	□	D.C.		Washi	natoN			1 64	LIMITS? YES 2 \(\) NO
150	FUNERAL	201 36 H S	7. N.E.		20019	7	10g. CITIZE	S.A.	COUNTRY?
5-0020 nding physician.	BY FUI	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 TYPES IF YES, GIVE WAR OR DATE	2 NO If y	S DECENDENT OF HISP. es, specify Cuben, Maxie YES 2 NO Spec	can, Puarto Rican, et		4. RACE — An Black, White	1.
21 atte	E	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION 10	8a. DECEDENT'S USUAL OCCU	JPATION	18b. KIND O	F BUSINESS/INDU	71-50	
	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Salesma		Pri	vate		
e de the	00	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S N	IAME (First, Middle, M	aiden Sumame)		
MARYI stained by should be tiffed at	BE	Jesse Jete 19a. INFORMANT'S NAME (Type/Print)	<u>r</u>	Total Mall INC appropries	Julia	Steve	15		
5 50 5	2	La Jugu Je	ter	201 36 H		E. Was	r Town, State, Zip C	. 200	19
RE, may be or, page		20a, METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Ramon	20b.Pl	ACE AND DATE OF DISPOSITION		7	G. LOCATION — CI	ty or Town, St	
Page 6 may al director, p		4 Donation 5 Other (Specify)	- Ho	COMONV CE	metery .	2/3/95 1	-ANCOVE	2. M	Zd.
ALT death. funera		21. SIGNATURE OF FUNERAL SERVICE LICE	dwards) (22. NAI	ME AND ADDRÉSS OF F	PACILITY HOO	iges +	Edev	9 ds. 20146
within 24 hours aft pletely filled in by cremation, or remo		23. PART I. Enter the diseeses, or conshock, or heert failure. LimmEDIATE CAUSE (Finel diseese or condition resulting in death)	ist only one ceuee on eacl	D ALCOHOL INTOX	ICATION	ch as cerdiec or	reepiratory srres	st,	Approximats interval Between Onset end Death
P.O. BOX 68 th certificate be execu- ending physician and i Hygiene prior to bur or other traumatic	CERTIFICATION	Sequentielly liet conditions, if sny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO						
RDS at the of by the and Mer	A	PART II. Other significent conditions OLD BRAIN CON	contributing to death but	not resulting in the unde	rlying cause given in		AS AN AUTOPSY RFORMED?	AVAILA	AUTOPSY FINDINGS ABLE PRIOR TO
RECOR	MEDIC		1001011, 02.	EZONE DIBO	ND LIK	- 1 DXY	ES 2 NO	OF DE	
	2	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES I NO	UNCERTA	IN []		1 [X]	YES 2 NO
VITAL F IAN: The law tificate has be e State Dept. or item 23 s	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH (Check only					
	YSI	1 XYES 2 NO	1 Inpatiant 2XXER/Outpatie	orther:	Home 5 - Residence	8 Other (Specify)		
NO PROPERTY OF THE THE CO. THE THE CO. THE THE CO. THE THE CO. THE THE THE THE THE THE THE THE THE THE		27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	INJURY	c. INJURY AT WORK?	28d. DESCRIBE H	OW INJURY OCCU	REO	
death death	ВУ	2 Accident Investigation	2/3/1995 28a, PLACE OF INJURY —	At home, farm, streat, factory,	YES 2 NO	SUBJE(CT INJE		DRUGS
产自主。	COMPLETED	8 X Could not be 4 Homicide datarmined	building, atc. (Specify)	AT HOME	dilice	200 fr Towns	ATHANST		N.E.
Hours Hom	F	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICI	AN: To the best of my knowledg		data and pieca, and du				
SPITE SPITE	NO.	2X MEDIGAL EXAMINER		nd/or investigation, in my opini					manner sa stated.
TO THE HOSPIT TO THE FUNGS INC. Be flee within 72 hours a	H	ON SUNATURE AND TITY OF CERTIFIES	A mel /	Por	29c. LICENSE NU		•	SIGNED (Month	or year.
	유		COMPLETED CAUSE OF DEATH		1 O.C.N			'R 9,	1995
7		DONALD G. WRIGH	T.M.D. 11	11 PENN STE	REET, BAI	LTIMORE	MARYL	AND 2	21201
	- 11	LEDT (1990 Am							

	Pages		
VSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	IR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pac		at
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age 6	direct		E
ath. P	Jueral		is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified
ter de	the fi	oval.	al ex
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ted w	сошр	al, Cr	eve
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tificat	g phys	In death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	ther
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DIRECTOR

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CERTIFICATION

PHYSICIAN: MEDICAL

В

COMPLETED

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31. DATE FILED (Month

Augus

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ny

St. Paul

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH arl 55 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 1 M 2 X F 228-22-9317 YRS. 80 JUNE 23, 1914 VIRGINIA 9a. FACILITY NAME (If not institution, give street and number 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MERCY HOSPITAL BALTIMORE CITY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE CITY 1 XYES 2 NO 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 607 DENNISON STREET 21229 USA. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 TES 2 X NO Specify Specify: 3 X Widowed 4 Divorced BLACK 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working tife. Do NOT use retired.) 15. DECEDENT'S EDUCATION pecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 12th GRADE CHILD CARE PROVIDER PRIVATE FAMILY 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) WILLARD JAMES CURRY FELICIA WONSOM 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) FELICIA GAULT 1504 AISQUITH STREET, BALTIMORE, MARYLAND 21202 20e. METHOD OF DISPOSITION

| X | Burlel | 2 □ Cremation | 3 □ Removat from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE ☐ Donetion 5 ☐ Other (Specify) BALTIMORE NATIONAL CEMETERY -95 BALTIMORE, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD.21223 23. PART I Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. interval Batween IMMEDIATE CAUSE (Final Onset end Daath disease or condition resulting in death) acute leukenia DUE TO (OR AS A CONSEQUENCE OF): phicemua Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if eny, leeding to immediate acuk renal cause. Enter UNDERLYING acture CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF that initiated events resulting in deeth) LAST Cancer CLYUNK PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Realdence 6 □ Other (Specify) Inpatient 2 - ER/Outpatient 3 - DOA 27. MANNER OF GEATH 26b. TIME OF INJURY 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26d. DEȘCRIBE HOW INJURY OCCURED t Natural 1 YES 2 NO 2 Accident Investigation 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 3 Sulcida 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER

29d, DATE-SIGNED (Month, Day, Year)

21202

MID

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DHMH-18 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

BALIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	Entition of the state has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
DIGINAL MECURDS, P.O. BOX 68/60	THOUSE ANY The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	CIUM: This certificate has been signed by the attending physician and completely filled in by the factor of the state Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.	28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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١.	John	Η.
4. S	OCIAL SE	CURIT

	HEGISTHAH		CERTIF	ICATE O	F DEATH	REG. I	NO.							
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	DAY	3. TIME OF DEATH						
	John H. Kopp	5. 9EX 6. AGE				February		995						
	214-16-3355		(In yrs. lest birthdey)	MONTHS DAYS		7. DATE OF BIRTH	haa	BIRTHPLACE (State or Foreit Country) MD						
	9a. FACILITY NAME (If not institution, give :		/ <u>1</u> Tha.	AL OUTY TOWN										
	1219 Vermont Rd	,			N OR LOCATION OF D	EATH		TY OF DEATH						
	RESIDENCE OF DECEDENT			ве.	l Air		На	arford						
	10e. STATE 10b. COUNT	Y	10c. CITY	Y, TOWN OR LO	CATION			10d. INSIDE CITY						
	MD	Harford	_	Bel Ai	c c			1 YES 2 NO						
	10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZI	EN OF WHAT COUNTRY?						
	1219 Vermont Rd				21014		U.	S.A.						
	11. MARITAL STATUS	12. WAS DECEDENT EVER I	2 100	13. WAS 0	ECENDENT OF HISPA specify Cubers, Maxics	NIC ORIGIN? (Specify	Yes or No- 1	14. RACE — American Indian, Black, White, etc.						
ĺ	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, OIVE WAR OR C	ATES		ES 2 NO Specif			White						
I														
١	15. DECEDENT'S EOU (Specify only highest grade	completed)	16a. DECEDENT'S (Give kind of w life. Do NOT us	vork done during		16b. KIND OF	BUSINESS/INDU	ISTRY						
	Elementary/Secondary (0-12) Unk.	College (1-4 or 5+) Unk .	Steelw			Ste	0.1							
	17. FATHER'S NAME (First, Middle, Last)	OHA.	Dreetw	OLKEL	10 MOTHER'S NA	ME (First, Middle, Mak								
	John Kopp				Anna He	The second second	en sumame)							
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILINO	ADDRESS (Street	t and Number or Rural		Town State Zin (Code						
1	Eleanor Kopp				Rd. Bel			3000)						
1	20e METHOD OF DISPOSITION	201	D. PLACE AND DATE O	F DISPOSITION	Neme of			Ity or Town, State						
20e, METHOD OF DISPOSITION 1 Buriel 2 Cremellon 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemallor) Cremellon 5 Other (Specify) Bel Air Memorial Gardens 2/20 Bel Air, MD														
1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY B. Dabrowski & Son Funeral Home													
	N. 195 /	1/20	Kelda											
۲	2818 E. Baltimore St. Baltimore, MD 21224 23. PART I. Enter the diseases, or complications that caused this death. Do not enter the mode of dying, such as cardiac or reapiretory arrest, ahock, or heart failure. List only one cause on each fine. Approximate interval Return													
	anock, or heart failure.	List only one cause on e	each line.	or enter the t	noda or dying, suc	in an cardiac or re	apiretory arres	Interval Bets						
	iMMEDIATE CAUSE (Final disease or condition	1115,00	7(8):		-(0			Onset and D						
i	resulting in death)	BI. DUE TO (OR AS	A CONSEQUENCE OF		Can	ca)		6 m						
		al. DUE TO (OR AS).	· M	contra	R.L.	Drune -	_	Vins						
1	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF	7(7)	1 so outing			17/-						
	cause. Enter UNDERLYING CAUSE (Disease or Injury	c.												
	that initiated events	DUE TO (OR AS	CONSEQUENCE OF	7:										
CENTIL ICATION	resulting in death) LAST	d												
	PART II. Other significant condition	es contributing to death i	out not resulting l	n the underly	ing cause given in	Part I 24s UNC	AN ALITOPSY	24b. WERE AUTOPSY FIND						
	Roberson	Ayrh			ang caase groom in	PERI	FORMED?	AVAILABLE PRIOR TO COMPLETION OF CAU						
						1 _ YES	2 NO	OF DEATH?						
	DID TOBACCO USE CONT	DIRLITE TO CALISE C	NE DEATH VE	SVZIMO	UNCERTAI			1 TES 2 NO						
	25. WAS CASE REFERRED TO MEDICAL	The cause of	26. PLACE OF DEAT			1 🗆								
	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Out		OTHER.	ome 5 Atesidence									
	27. MANNER OF DEATH	28e. DATE OF INJURY	28b, TIME		NJURY AT	28d. DESCRIBE HO	W INJURY OCCU	IREO						
- 1	1 Natural 5 Pending	(Month, Day, Year)	INJ	URY Y	YORK? YES 2 NO	100. 020002 110		, neb						
1	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	/ — At home, farm, s			28f. LOCATION (Stre	et and Number o	r Rural Route Number,						
	4 Homicide detarmined	building, etc. (Spe	cify)			City or Town, Sta	ife)							
	29a. CERTIFIER CERTIFYING PHYS	CIAN: To the heat of my know	dedos desth segues	d of the stars of	te annual annual annual									
		CIAN: To the best of my know R: On the basis of examination												
	29b. SIGNATURE AND TITLE OF CERTIFIE			,, opinion			-							
	- THE OF CERTIFIE				29c. LICENSE NUI	- 1	29d, DATE S	SIGNED (Month, Day, Year)						
	30. NAME AND ADDRESS OF PERSON WH	C COMPLETED CAUSE OF DE	ATH (ITEM 27) /Tune	Print)	10247	- 10	1	-1715						
	DR Simou	11 CN A	1 11 A	29	no E	Box L'	10.00	ST						
	31. DATE FILED (Month, Day, Year)	32_REGISTRAR'S SIGN	ATURE	0/1	10 E.	111711	MORE	-111						
	FEB 1 71995	The Bridge	24											
- 18		AT MANY BY SAME												

and the transferred

DIVISION STOCKED WITH ALL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR A HOME AND A RECORDS AND STATEMENT OF THE HOSPITAL OR A HOME AND A RECORDS AND A RECORD OF THE HOME ALL DIRECTOR, AND THE FLYREPAL DIRECTOR, AND THE FLYREPAL DIRECTOR, AND THE FLYREPAL DIRECTOR AND THE FLYREPAL DIRECTOR, AND THE FLYREPAL DIRECTOR AND THE

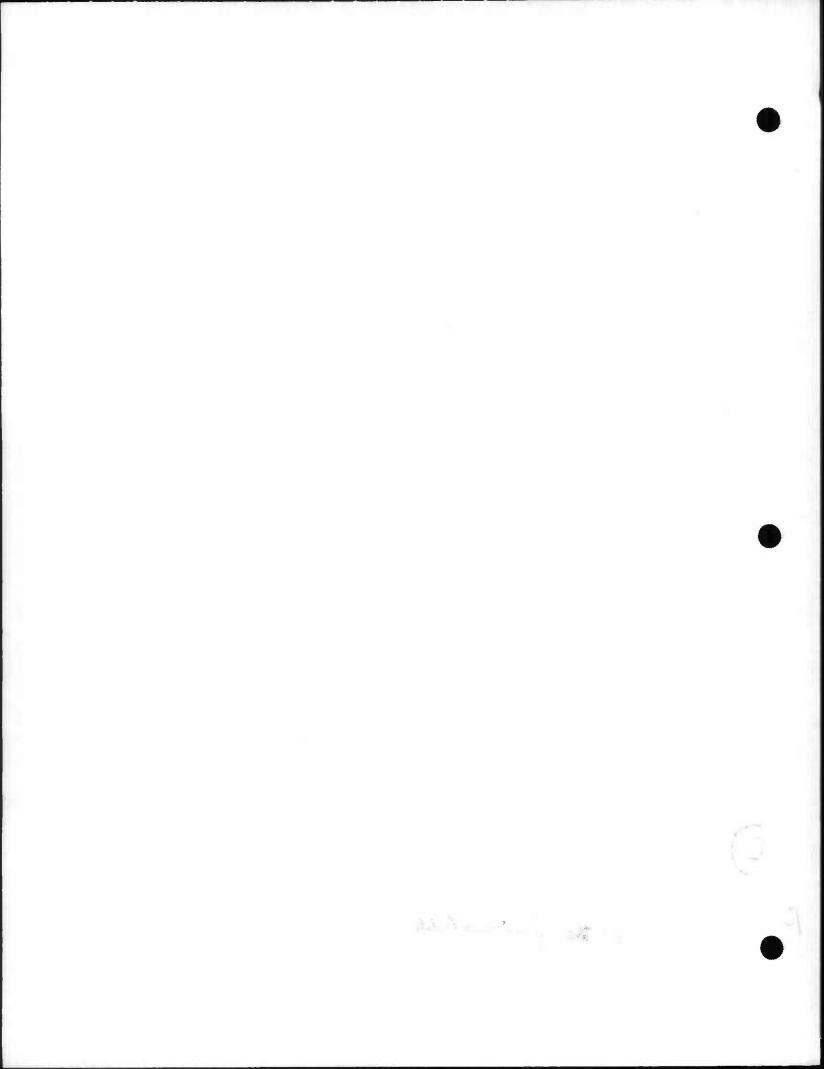
FOR

	1 - STATE REGISTRAR		CE		ICATE OF			WILLY I	REG. NO	_		
	1. DECEDENT'S NAME (First, Middle, Last)							2. DA1	E OF DEATH			3. TIME OF DEATH
	ISOLDE	IRMGAR	D	KLL	JGE			MON	Feb 1		YEAR	10:47 am w
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER 1 YEAR	IF UNDER	24 HRS.		E OF BIRTH		8. BIRTH	PLACE (State or Foreign
ı	213-38-5528	1 M 2 XF	89	YRS.	MONTHS DAYS	HOURS	MIN.		nth, Day, Year)	1905	CEDN	
	9e. FACILITY NAME (If not institution, give	street end number)			9b. CITY, TOWN	OR LOCATI	ON OF DE				INTY OF D	
8	Saint Joseph MED	DICAL CENT	FR		To	WSOR	Mar	vien	d 21204		TOW	ISON.
5	RESIDENCE OF DECEDENT						TVICE	yickii	0 2:207		1011	10011,
DIRECTOR				10c. CIT	Y, TOWN OR LOCA	TION						10d. INSIDE CITY LIMITS?
		TIMORE		T	MSON							1 TES 2 NO
R	10e. STREET AND NUMBER	101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?						YHAT COUNTRY?				
FUNERAL	905 SOUTHERLY ROA					212					US	
	1 Never Merried 2 Merried	12. WAS DECEOENT FORCES? 1	YES 2 X	MED 10	13. WAS DE	CENDENT Cooking	F NISPAI	NIC ORIG	IN? (Specify Yes Rican, stc.)	or No-	14. RACE Black	— American Indian, c, White, etc.
B	3 X Widowed 4 □ Divorced	IF YES, GIVE WA	AR OR DATES		1 🗆 YE	2 2 NO	Specify	y:			Specif	ty:
	15. DECEDENT'S ED	JOATION	16a. DE	CEDENT'S	USUAL OCCUPAT	ON		10	b. KIND OF BU	SINESS/IN	DUSTRY	WHITE
Ш	(Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	- IIIn	ive kind of Do NOT u	work done during rr se retired.)	ost of workir	g					
릴	12			Н	OME MAKE	R				7/171 1	HOME	
COMPLETED	17. FATNER'S NAME (First, Middle, Last)				1444		VER'S NA	ME (First	Middle, Maiden		NO MEL	
BE	BERNHARDT		KUENZEL			ME	rα		ROSA		wor	LUCKNER
0	19a. INFORMANT'S NAME (Type/Print)		198	. MAILING	ADDRESS (Street		_	Route Nu				HUCKNER
-	ISOLDE BROOKE			206 1	E. SEMIN	ARY A	AVE I	LUTE	ERVILL	E. MI	21	093
	20a. METHOD OF DISPOSITION 1 N Burlet 2 Cremetion 3 Ren	noval from State	20b. PLACE	NDDATE	OF DISPOSITION (A			1			City or To	
	4 Donation 5 Other (Specify)		DULANI		ALLEY CE	Μ.		2/17	/95 TI	MONTI	IM. M	מו.
	21. SIGNATURE OF FUNERAL SERVICE LI	JUHI	N E. DOI	LAN	22, NAME A		SS OF FA	CILITY				
	16hm 10	Jolan							RAL HO			
	23. PART I. Enter the diseases, or	complications that	caused the de	ath. Do i	not sntsr the m	ods of dyl	ng, auc	h aa ca	rdisc or respi	ratory an	rest.	Approximate
	shock, or heart failure. IMMEDIATE CAUSE (Final	List only ons caus	e on esch lins									Interval Between Onset and Death
	disease or condition resulting in death)											
i	resulting in death)	* CRITICAL	OR AS A CONSEC	UENCE O	NOSIS							2 HOURS
Z	Sequentially list conditions,	L LINGTAR	E ANIGIN	AL								
CERTIFICATION	is any, resuming to immediate	· UNSTAB	OR AS A CONSEC	VENCE O	F):							
5	CAUSE (Disease or Injury	C. LEFT HE	ART FAIL	JAE								
Ë	that initiated events resulting in death) LAST	DUE TO (C	OR AS A CONSEC	UENCE O	F):							i 1
8		"-CARDIO	BENIC SH	HOCK	CARDIA	ARE	REST					
7	PART II. Other algnificent condition	ns contributing to d	sath but not n	sulting	in the undarlyir	g csuse (Iven In	Part I.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS
DICAL									PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME									1 163 2	X		OF DEATH? 1 ☐ YES 2 ☐ NO
ž	DID TOBACCO USE CONT	RIBUTE TO CAL	JSE OF DEAT	TH YE	S 🗆 NO [JUNC	ERTAIN	VΠ				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				TN (Check only one							
Sign	1 TYES 2 NO	HOSPITAL:	ER/Outpetient 3	□ DOA	OTHER: 4 Nursing Nor	10 5 □ Ra	sidence	8 Oth	er (Specify)			
£ 1	27. MANNER OF DEATH	28e. DATE OF III (Month, Day		28b. TIM	E OF 28c. IN	IURY AT			SCRIBE NOW II	JURY OC	CURED	
BY	1 Netural 5 Pending 2 Accident Investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	. 1027	1140		YES 2	Uvo					
	3 Suicide 8 Could not be	28e. PLACE OF building, at	INJURY — At hor	ne, term, i	street, factory, offi	a	^	281. LO	CATION (Street a	nd Number	or Rural R	oute Number,
COMPLETED	4 Nomicide determined							On,	or lown, otale)			
2	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the beat of m	ny knowledge, des	ith occum	ed at the time, date	end plece,	and dua	to the ca	tuse(s) and men	ner ea stat	led.	
OM												end manner ee stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE					29c. LICE						(Month, Day, Year)
H	Luck W.	resul	20							DAI	J _ A	(mondi, bay, real)
2	30. NAME AND ADDRESS OF PERSON WA	O COMPLETED CAUSE	OF OEATH (ITEM	1 27) (Type.	Print)	_018	408				^ 1	
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	FEB 1 7 1995		a Bulgia,	SUITE	409							
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	1
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		FOR STATE REGISTRAR	STATE OF N	MARYLAN	ID / DEPAR	TMENT OF	HEALTH AND	MENTAL HYGI				
		1. DECEDENT'S NAME (First, Middle, Last)	VI I					2. DATE OF OEATH MONTH	DAY	YEAR	TIME OF DEATH	_
	1	RUSSELL 4. SOCIAL SECURITY NUMBER	5. SEX	ETTER,	, SK.	IF UNDER 1 YEA	AR IF UNDER 24 HRS.	FEB 13			ACE (State or Foreign	M
pino		213-16-6038 9a. FACILITY NAME (If not institution, give s	1 M 2 🗆 F	73	YRS.	MONTHS DAY		JUNE 16	5 1921	Country)	YLAND	
1, 2, 3 should	CTOR	3905 BELLE OF GE	-000	ENUE			PASADENA	ZEATH		E ARU		
Pages	DIRE		v NE ARUNDEL	L	10c. CIT	Y, TOWN OR LO GLE	EN BURNIE				d. INSIDE CITY LIMITS? YES 2 NO	
an. ransit permit.	NERAL	760 NABBS CREEK R					21061			USA	T COUNTRY?	
215-0020 attending physician. se as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	X YES 2	2 NO	If yes,	DECENDENT OF HISPA , specify Cuban, Mexic YES 2 A NO Speci	ANIC ORIGIN? (Specify can, Puerto Rican, etc.) ify:	Yes or No—	Black, W	American Indian, hite, atc.	
or atte	LETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	JCATION a completed) College (1-4 or 5 +		Ille. Do NOT us	work done during se retired.)	ATION most of working		BUSINESS/INDU			
The hospital detached to once.	COMPI	7 17. FATHER'S NAME (First, Middle, Last)			CARP	ENTER		AME (First, Middle, Meld	den Surname)	TEM R	AILROADS	_
5 2 To	BE	ROBERT KLETTER 190. INFORMANT'S NAME (Type/Print)			405 4448 800			BARA WHITE				
E, MAR ay be retained page 5 should be notified	10	LINDA S. SOMERS			3905	BELLE (OF GEORGIA	A AVENUE,	PASADE	NA, M		
IMORE Page 6 may I director, pa		20e, METHOD OF DISPOSITION 1 \(\tilde{\Omega}\) Burlel 2 \(\tilde{\Omega}\) Cremetion 3 \(\tilde{\Omega}\) Rem 4 \(\tilde{\Omega}\) Donation 8 \(\tilde{\Omega}\) Other (Specify) \(\tilde{\Omega}\)	icval from State		ACE AND DATE OF PROPERTY OF PR				GLEN BU			
ALI death. funera		21. BIGHATURE OF FUNERAL SERVICE CR	STATE OF THE PERSON OF THE PER	1	////	STAL	LINGS FUN		, P.A.			_
d within the hours after of myletely filled in by the cremation, or removal event, the medical event, the medical		23. PART I. Enter the diseases, or o shock, or heart feilure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	P.	0 5 7	ine.	not enter the	mode of dying, suc	ch as cerdiac or re	spiratory arre	et,	Approximate Interval Between Onset and Death	
5, P.O. BOX 6870 death certificate be executed attending physician and committee prior to buna, into or other traumatic et	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c		DNSEQUENCE OF							
that the ed by the th and Mi	MEDICAL C	PART II. Other algolificent condition	e contributing to	death but r	not resulting i	n the underly	ring ceuse given in	PERF	AN AUTOPSY FORMED?	COL	RE AUTOPSY FINDINGS NILABLE PRIOR TO MPLETION OF CAUSE DEATH?	
law requals been bept. of 23 she	AN: ME	DID TOBACCO USE CONTI	RIBUTE TO CA					N 🗆			YES 2 NO	
# 2 8 E	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		PLACE OF DEAT	OTHER: 4 Nursing H	1 -	6 ☐ Other (Specify)				
子語音	ву рну	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF I	INJURY	28b. TIM	E OF 26c.	INJURY AT WORK? YES 2 NO	28d. DESCRIBE HO	W INJURY OCCU	IRED		
ATTENDING HECTOR: After NITS after death IN 28 IS Mai	ETED B	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF building, (F INJURY — / etc. (Specify)	At home, ferm, s	treet, fectory, o	ffice	281, LOCATION (Stree City or Town, Sta	et end Number o	r Rural Route	Number,	
UNESPORTED THE COLUMN TO A COLUMN TO COLUMN THE COLUMN	COMPLE							e to the cause(e) end r			d menner se stated.	
DO THE DE SE	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER	Inlow	the	ans		29c. LICENSE NU	738	•	2//	onth, Day, Year)	
			CGGT		(ITEM 27) (Type,	Print) 95	Aqua	La-TR	1. 614	ic Bu	ionil AP Zie	0
ľ		31, DATE FILED (Month, Day, Year)	1 A22 B	CONTRACTOR OF	Marie							_



		1. DECEDENT'S NAME (First	t, Middle, Last)	1/							2. DAT	E OF DEATH	DAY _	YEAR	. TIME OF DEATH	
		4. SOCIAL SECURITY NUMBER	nen.	KURL							FEB	URARY	9	95	15:53 p.M	
		199-09-9618		5. SEX		yrs. lest birthday	MONTHS	DAYS	HOURS	R 24 HRS.	(Mon	th, Day, Year)	1010	Country)	ACE (State or Foreign	
should		9a. FACILITY NAME (If not in				J 1113.	9h CIT	y TOWN	OR LOCAT	ION OF DE		. 29,	1919	Penn	sylvania	
2, 3 sh	DIRECTOR	6809 Massen	ia Cou					thes		TON OF DE	-AIII			ontgon		
les 1,	EC	RESIDENCE OF DEC	10b. COUNT	Υ		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY				
permit. Pages	DIR	Maryland	Mor	ntgomery		Bethesda								LIMITS?		
	AL	10e. STREET AND NUMBER					10f. ZIP CODE						10g. CIT		AT COUNTRY?	
an. ransit	FUNERAL	6809 Massen	ıa Cour				20817							USA		
020 physician. burial-transit	F	11. MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDEN	YES	2 NO	13.					N7 (Specify Ye Ricen, etc.)	a or No-	14. RACE Black, 1	- American Indian, White, sic.	
- Pag a	В	3 Wildowed 4 Divo		WWII	MAR OR DATE	ES		1 TYES	2 XNO	Specify	r:			Specify:	White	
1215-0 r attending use as the	ED		EDENT'S EDU	CATION	10	6a. DECEDENT	S USUAL C	CCUPATI during me	ON ost of work	ina	16	b. KIND OF BL	SINESS/IN	DUSTRY		
	COMPLET	Elementary/Secondary (0	1-12)	College (1-4 or 5	+)	Ille. Do NOT	use retired.)					77				
AND 2 the hospital detached to once.	OMF	17. FATHER'S NAME (First, M	liciciia I asti	4 Yrs		Nurse			40 1407	115010 111		VA Hos	-	<u> </u>		
YLA by the be det	E	Samue1	,,	uro					1 .	nna l		Middle, Malder	Surname)			
MARYLAND retained by the hospit 5 should be detached notified at once.	00	19a. INFORMANT'S NAME (7				19b. MAILIN	G ADDRES	S (Street				nber, City or Tox	vn, State, Zi	p Code)		
	5	Neil Ku	ırland												227-6122	
		20 METHOD OF DISPOSIT	n 3 🗆 Rem	oval from Stata	20b. Pl		2 Ducketts Lane, Elkridge, Maryland 21227-6122 ATEOFDISPOSITION (Name of 2/14/1995 20c. LOCATION - City or Town, State Arlington, Virginia 22. NAME AND ADDRESS OF FACILITY									
MO directs		4 ☐ Donation 5 ☐ Other 21. SIGNATURE OF FUNERA		ENGEE	Arl	lington	Nat	iona	1 Ce	mete:	rÿ	Arl	ingt	on, Vi	rginia	
ALTIMOR death. Page 6 mi funeral director,		L. SIGNALORE OF FOREIGN	· · ·	-ENSEE							-		UNER	AL HOM	Æ, INC.	
BA rs after de removal.		Gonal	d.C.	xaol	There	yer	2	32 C	ARRO	T.T. S	r N	TAT TATA S	HTNC	TON T	C 20012	
BALTIN hours after death. Pag ed in by the funeral di or removal. medical examiner		23. PART I. Enter the di shock, or he	esrt fallure.	complications the List only one ceu	et ceused thuse on sect	Ke deeth, Do n line,	not enter	the mo	ode of dy	ing, sucl	h as car	disc or resp	iratory ar	rest,	Approximate interval Between	
		IMMEDIATE CAUSE (Findisease or condition	nai	1001			7		4 10 -		-	7			Onset and Death	
or withing of withing of withing of withing of withing of withing or went, the		recuiting in desth)	-	S. IVI Y D C	OR AS A C	ONSEQUENCE	/	71-1	PRC	TI	ON				ACUTE	
687 ecuted ind com burial, atic ex	2			ARTER	10500	LEROT	1C	(A)	8010	VASO	C 11	AR	Dis	FACE.	ACUTE	
OX 68 e be execute sician and corior to buria traumatic	CATION	Sequentially list condition if any, leading to immediately	diste	DUE TO	(OR AS A CO	ONSEQUENCE	OF):					7 7 7				
ficate physic ne pri	일	CAUSE (Disesse or Inju		c	(OR AS A C	ONSEQUENCE	ne.				_					
P. O. Hygien	토	that initisted events resulting in desth) LAS	т	4	(an na n an	511020021102	or).									
S, deat deat le atte	CE	DART II Other significa	nt condition		4 45 5 4	. 6										
K # B S	EDICAL	PART II. Other significa			deeth but	not recuiting	In the U	nderiyin	g cause	given in	Part i.	24a. WAS AN PERFO		A	ERE AUTOPSY FINDINGS MILABLE PRIOR TO	
	EDI	INCREAS			FIFAA	/		-			_	1 TYES	NO		OMPLETION OF CAUSE F DEATH?	
2 5 5 5	M	DID TOBACCO U					FS 🗆	NO D	T UNC	ERTAIN	J 🗖			1	YES 2 NO	
has has	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?				PLACE OF DE			1 0110	LIVIAII						
F VITA SICIAN: The certificate h the State I	rsic	1 YES 2 NO		HOSPITAL:	☐ ER/Outpetk	ent 3 🗆 DOA	OTHE		6 5 A	naldence	6 🗆 Othi	er (Specify)				
PHYSICIAN: this certifical with the Str	РНУ	27. MANNER OF DEATH	Daniel III.	28a. DATE OF (Month, D	INJURY Day, Year)	26b. TI	ME OF		URY AT		26d. DE	SCRIBE HOW	INJURY OC	CURED		
STON OF FENDING PHYS OR: After this fer death with 8 is marked	B	2 Accident	Pending Investigation	260 BLACE O	NE IN ILIPA	44.5	М		YES 2	NO						
ITENDING TOR: After after death 28 is ma	8		Could not be determined	building,	atc. (Specify)	At home, farm,	street, fac	tory, offic			281. LOC	CATION (Street or Town, State	and Numbe	r or Rural Rou	te Number,	
S S S W	Ē	29a. CERTIFIER 1 CERT	IFYING PHYSI	CIAN: To line best of	mu kaawlad	es doub sour		W d-1-								
三世 二	COMPL														nd manner as stated.	
THE CONTRACTOR IN PORTANT	ECC	250. SIGNATURE AND TITLE			//.	P				ENSE NUM		Nett /	1	E SIGNED (M		
五 日 3 2 2	m-4	Sec. 11	ne O	Muyle	All	0			Do	70	99	7	D.F.	BILLA	ey 9 95	
41 -	2	30, MAME AND ADDRESS OF	PERSON WH	O COMPLETED CAU	BE OF DEATH	(ITEM 27) (Typ	e, Print)	2	X				111	JUNIT	1 10	
17.		FRANCES (- M	MY4810	A THEORY OF	RNW.	ocab	KD	\$	374	165	BA 1	Mo	208,	17 1106	
10		31. DATE FILED (Month, Day,	an A	PEGLITE.	the factorial	ME										

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

. . . Address to the second

	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mous after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached the first mitted 20 bears after death with the Class Dear of March Labrican price to bridge or proposed.	be life within 12 from state beats with the State Dept. Or regular and mental regime, prior to busing, chemistron, or removal. IMPORTANT: If them 28 is marked, or flem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	E :	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the face signed to the first action of second to the first and Marcel Laborate and Marc	ltem
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Item#1.G-film 720 per F.H 2/17/95 PC
FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REGISTRAR
CERTIFICATE OF DEATH

	REGISTRAR		CERTIFIC	CATE OF	DEATH	R	EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF D	EATH		3.	TIME OF DEAT	īN
	Janet Loui	Se	Lehman			Februa	DAY	3, 19	AR		- 4
	4. SOCIAL SECURITY NUMBER 179-32-0491			IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B				10:40 ACE (State or Fo	a
	179-32-0491	1 M 2 X F		ONTHS DAYS	HOURS MIN.	(Month, Day	; Year)		Country)		
	9a. FACILITY NAME (If not institution, give str					Nov.23	.194			SYLVAN	IA
œ					OR LOCATION OF DE	EATH		9c. COUNTY			
DIRECTOR	Greater Baltimore	Medical Ce	enter	Tows	on			Balti	more	e	
S	10a. STATE 10b. COUNTY			TOWN OR LOCA	TION				10	d. INSIDE CITY	,
<u>۾</u>	MARYLAND BALT	IMORE		OCKEYS						LIMITS2	
	10e. STREET AND NUMBER	HORD								YES 2	NO
FUNERAL		one Gate Co	urt	10	21030			10g. CITIZEN		T COUNTRY?	
빌											
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED	13. WAS DEC	ENDENT OF NISPAN	IIC ORIGIN? (Sp n. Puerto Rican.	ecify Yea o	No- 14.	RACE - Black, W	American India	en,
B≺	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES		2 No Specify				Specify:		
	15. DECEDENT'S EDUC	ATION		1					WHI	TE	
1	(Specify only highest grade of	completed)	(Give kind of wor life. Do NOT use i	k done during me		16b. KINO	OF BUSII	NESS/INDUST	RY		
2	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Nurs			TI II	021+	h Care	2		
COMPLETED		0	Nuls	е					=		
8	17. FATHER'S NAME (First, Middle, Last)	77 70			18. MOTHER'S NA						
BE	Sterling	r. Bear				thy Lou					
2	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural F					1000	
	Paul E. Lehman		4 St	one Ga	te Court,	, Cocke	ysvı	He, I	1D Z	1030	
	20g. METHOD OF DISPOSITION 1 Burlel 2 Committee 3 Remo	val from State	b. PLACE AND DATE OF metery, crematory or other		me of	DATE	20c. LOCA	ATION — City	or Town,	Stata	
- 1	4 Donation S Other (Specify)		Sater Hil	1 Bapt		16 FFB	Luth	ervil]	e. I	MD	
	21. SIGNATIONE OF PUMERAL SERVICE LICE	MSEE) ,)		D ADDRESS OF FAC	CIUTY					
	Lowell M.	Lemmon	nu		mmon Fune						
\neg	23. PART i. Enter the diseases, or co		d the death. Do not	10	W. Pador	nia Rd	Tim	onium	_MD		
	ahock, or heart failure. L	isi only one ceuse on	each line.	onter the mo	de or dying, add	I de Cardiac (or reapira	itory erreat,		Approxima	
	iMMEDIATE CAUSE (Final disease or condition	Mataatata	a 1 Ca.							Onset and	
	resulting in death)	Metastati		cinoma						11 mo	nths
		DUE TO (OR AS	A CONSEQUENCE OF):								
S S	Sequentially list conditions, b.										
Ē	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OH AS	A CONSEQUENCE OF):								
일	CAUSE (Disease or injury C.	OHE TO (OR AS	A CONSEQUENCE OF):							-	
Ē	that initiated events resulting in death) LAST	OUL TO (ON AS	A CONSECUENCE OF).								
CERTIFICATION	d.										
ايد	PART ii. Other aignificant conditions	contributing to death	but not reaulting in	the underlying	cause given in		WAS AN AL			RE AUTOPSY FIL	
MEDICAL							PERFORM	700		AILABLE PRIOR '	
						— 'X	YES 2	NO		DEATH?	
2						-			1)	YES 2 N	10
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			20 DI	ACE OF OFATH (Ch.	at act act)					
를 기	EXAMINER?	HOSPITAL:		THER:	ACE OF OEATN (Che						
₹	1 YES 2 NO 27. MANNER OF DEATN	1 Inpetient 2XI ER/Out			e 5 🗆 Residence						
	1 X Natural 5 Pending	(Month, Day, Year)	28b. TIME C	Y WO	RK?	28d. DESCRIBI	E HOW INJ	URY OCCUR	:D		
B	2 Accident Investigation				ES 2 NO						
- 1	3 Suicide 8 Could not be 4 Nomicide determined	28a. PLACE OF INJUR building, etc. (Spe	Y — At home, farm, struckly)	et, factory, offic	•	281. LOCATION City or Tow	(Street and	d Number or R	ural Route	3 Number,	
	a Nomicide Betermined										
E	29a. CERTIFIER 1 X CERTIFYING PHYSIC	AN: To the best of my know	wledge, death occurred	at the fime, date	and place, and due	10 the cause(a)	and manne	or as stated.			
COMPLETED	one) 2 MEDICAL EXAMINER								use(a) an	d menner as st	ated.
	29b. SIGNATURE ANO TITLE OF CERTIFIER	2.			29c. LICENSE NUM					onth, Day, Ybar)	
H	Richard M.	Miller Y.	440			well)	1				
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF O	EATN (ITEM 27) (Type Pr	int)	D27740			- 02	/14/	95	
				,	C4	D 3		MD OF	204		
	Robert A. Palermo	M.U GBN	1C 6701 N	unaries	Street,	Balti	more	MU 21	204		
	FER 1 7 1995	i Seriem-Re									
	FERTURYS do	was married to	THE RESERVE THE PERSON NAMED IN								

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

FEB 1 7 1995

		1. DECEDENT'S NAME (First, Middle, Last)
		A Lampe Million V
		- 17 19 1 · 3
		MONTH'S DAYS HOURS MIN. (Month) Day, Near)
pino		as EACH ITY NAME (I sa I said
3 should	Œ	Sinai stract
1, 2,	18	RESIDENCE OF DECEDENT
. Pages	DIRECTOR	10c. CITY JOWN OR LOGATION 10d. INSIDE CITY LIMITS? 10 YES 2 N
020 physician. burial-transit permit. Pages	FUNERAL	100. STREET AND NUMBER 101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY?
Cian.	N	11. MARITAL BTATUS 12. WAS DECEDENT IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No — 14. RACE — American Indian.
	B	1 Never Merried 2 Merried FORCES? 1 A YES 2 NO If yes, specify Cuben, Mexicen, Puerto Rican, atc.) Black, White, etc. Specify: Specify: Black, White, etc. Specify: Black, White, etc. Specify: Specif
215 aften	G	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working
24 P	COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)
AN the hose detach	ő	17. SATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname)
	III I	199 MAFORMANT'S NAME (Typeppyint) 19b. MAILING ADDRESS (Street and Number or Rural Route Mymphoer, City or Typen, State, Elip Code)
	2	Michelle Lee 4110 Direchester Kd Balto 21215
RA may		20e METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Removal from State 29e PLACE AND DATE OF DISPOSITION Name of degletery, crematory or other place DATE 20c. LOCATION — City or Town, Blate
MO age 6 directo		1 Donation 5 Donation
ALTIM death. Page funeral direct.	33	27. SIGNATURE OF TUNESAL SERVICE LICENSEE 22ANAME AND ADDRESS OF FACILITY
		4300 wabash Ave
# F E S		23. PART i. Enter the diseasea, or complicatione that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,
		IMMEDIATE CAUSE (Finel
Tage II		disease or condition resulting in death) a. AIDS
		DUE TO (OR AS A CONSEQUENCE OF):
control of the complete of burial, creament of the complete of	1	Sequentially list conditions,
Cian be	CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING
BOX ficate be physician he prior t	[[CAUSE (Disease or Injury
eath certifical attending phy mal Hygiene p	Ē	that initiated events resulting in death) LAST
atte att	B	
D # # E	AL.	PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FIND PERFORMED? AMILIABLE PRIOR TO
RECOR requires that een signed by of Health an		End Stage Ferra Discase End Stage Ferra Discase 1 yes 2 No OF DEATH?
Quires quires n sign f Heal	WE	1 VES 2 NO
AL RE e law req has been Dept. of 23 she	ż	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN
SICIAN: The law certificate has the State Depth the State Depth of or Item 23	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER:
VIAN:	YSI	1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Recidence 8 Other (Specify)
OF PHYSICI this cer with th	표	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED
ON O OING PHYS After this death with	à	2 Accident Investigation Investigation Investigation
O IN A P		3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28e. LOCATION (Street and Number or Rural Route Number, City or Yown, Stete)
DIVIS OR ATTE ORRECTOR Hours after		
4 4 7 E	1 = 1	29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated.
HOSPITAL FUNERAL Within 72	ő	2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(a) and menner as state
TO THE HOSPIT TO THE FUNERA be filed within ?	BE C	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)
F F # Z	TO B	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AS 2402321-AG 9825 Feb 14, 1999 AS 2402321-AG 9825 Feb 14, 1999 AS 2402321-AG 9825 Feb 14, 1999 AS 2402321-AG 9825 Feb 14, 1999 AS 2402321-AG 9825 Feb 14, 1999
-1	-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
+1		Hexander 940 Sinai Hospital of Baltimore
		31. DATE FILED (Month, Day, Year) 32, REGISTRAR'S SIGNATURE

Julia Studier Reales

3. TIME OF DEATH 1:30 PM 6. SIRTHPLACE (State or Foreign 9c. COUNTY OF DEATH 10d. INSIDE CITY LIMITS? 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? . S.A 14. RACE — American Indian, Black, White, etc.

Specify: Back USINESS/INDUSTRY axwe (10 code) 21215 OCATION - City or Town, Blate Dwings mills, mo piratory arrest, Approximate interval Between **Onset and Death** years 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 2 NO INJURY OCCURED and Number or Rural Route Number,

Application of the LA

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within yours after death. Page 6 may be retained by the hospital or attending physician.
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		OIXIE OI II	C	ERTIF	ICATE O	HEALTH AND F DEATH	INICH IA	REG. NO				
1. DECEDENT'S NAME (First, M.	liddle, Last)						2. DATI	E OF DEATH	DAY	YEAR	3. TIME OF DEATH	
4. SOCIAL SECURITY NUMBER		ANCY 5, 9EX			IN	1 100000	FEB		19	995	9:00 1	
239-39-875		1 M 2 V F	6. AGE (In yrs. la	YRS.	MONTHS DAY			th, Day, Year)		8. BIRTI	HPLACE (State or Foreign (hina	
9a. FACILITY NAME (If not instit		- 11	20	1110.	Sh CITY TOW	N OR LOCATION OF	Dec	_30_1		NTY OF C	in in	
4637 Hallo	owed			Ellicott City Howard								
	Ob. COUNTY	1		10c, CI	Y, TOWN OR LO	CATION					10d. INSIDE CITY	
Maryland	Howa	ard		E11	icott	City					LIMITS?	
10e. STREET AND NUMBER						101, ZIP CODE		10g. CITIZEN OF WHAT COUNT				
4637 Hallo	owed	Stream				21043	101		Į	JSA		
11. MARITAL STATUS 1 Never Married 2 1 Ma	erried	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AI			ECENDENT OF NISP			ea or No-	14. RAC Blac	E American Indian, ck, White, etc.	
3 Widowed 4 Divorce		IF YES, GIVE W	AR OR DATES			ES 2 NO Spec				Spec	otty:	
15. DECED	ENT'S EDUC	CATION	16e, D	ECEDENT'S	USUAL OCCUP	NON	16	b. KIND OF BI	ISINESS/IN		ninese	
(Specify only hi Elementary/Secondary (0-12		completed) College (1-4 or 5 +	(0	Give kind of e. Do NOT u	work done during	most of working						
Entritorially (0-12	"	2+		Home	emaker		4	Dome	estic	2		
17. FATHER'S NAME (First, Midd	.,,					16. MOTNER'S N	AME (First,	Middle, Meide	n Surname)			
Hsieh Tar	ng Wi	u			VI DES							
19a. INFORMANT'S NAME (Type	/Print)					et and Number or Rura					21043	
Angela Wu				4637	Hall	owed St	ream	Elli	coti	c Ci	ty, Md.	
4 Donation 8 Other (Sc	pecify)		Balt	ematory or o	sh. Cre	(Name of					own, State	
21. SIONATURE OF FUNERAL S	SERVICE LIC	1 NO	- Balt 0544	:-Was	Sh.Cre 22. NAME Sla Ell	matoryI AND ADDRESS OF F	nc 2	Home	95 L:	aure A.		
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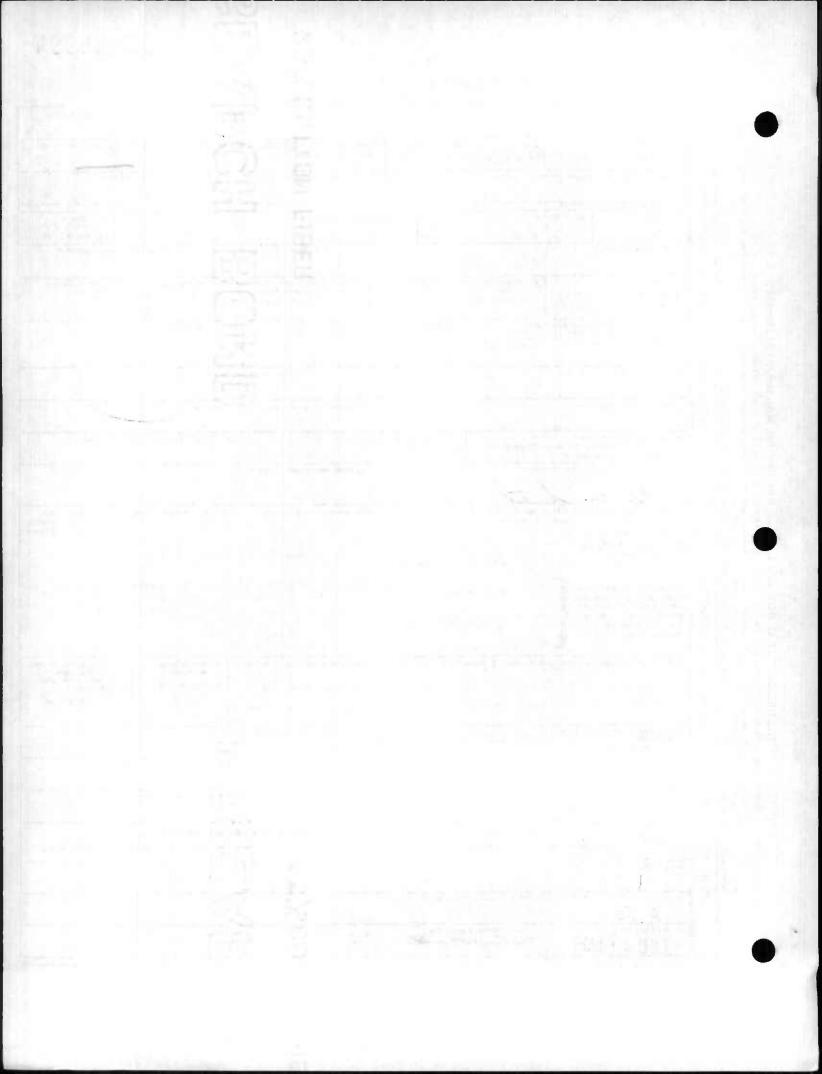
	and a title time, being process of the time, being mine p	nace, and ove to the cause(s) and market as a
29b. SIGNATURE AND TITLE OF CERTIFIER	29c, LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)

ماد (The 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

PETER CH	100/9 MO 2	
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE	
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STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) Landare Last 2. DATE OF OEATH MONTH 3. TIME OF DEATH YEAR Arnad Arnold Hacker Landgraff February
7. DATE OF BIRTHO 95 10:40 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign May 03, 1950 215584173 DAYS HOURS 44 1 M 2 - F Maryland permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Good Samaritan Hospital Baltimore RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 18c. CITY, TOWH OR LOCATION 10d. INSIDE CITY Maryland **Baltimore** Parkville 1 TYES 2X NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? is after death. Page 6 may be retained by the hospital or attending physician. If the funeral director, page 5 should be detached for use as the burial-transit premoral. 1616 Lyle Court 21234 USA 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yea, specify Cuban, Mexican, Puerto Rican, stc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indien, Black, White, etc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 Married Specify: White В 3 Widowed 4 Divorced 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) ETED. 15. OECEDENT'S EDUCATION 16b. KINO OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementary/Secondery (0-12) 12th College (1-4 or 5 +) COMPL Carpenter Construction 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maider Sumame) Theodore Stanley Landgraff notified at Lore Ann Hacker BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Lore A. Landgraff 1533 Providence Rd. Towson, MD 21286 be 20s. METHOD OF DISPOSITION
1 Durtel 2 X Cremation 3 Denioval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE must Metro Crematory, Inc. 02/16/95 4 Donation 5 Other (Specify) Baltimore, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. examiner executed within 24 hours after death, George E. MacNabb 299 Frederick Rd. Baltimore, MD 21228 medical 23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, filled in by ahock, Dr heart fallure. List Dnly Dne cause Dn each line. Interval Retween Onset and Death **IMMEDIATE CAUSE (Final** the cremation, disease or condition ardiac completely arres resulting in death) do min traumatic event, DUE TO (OR AS A CONSEQUENCE OF) and com ovolemic CERTIFICATION min Sequentially list conditiona, attending physician a ental Hygiene prior to 2 If any, leading to immediate cause. Enter UNDERLYING 2 certificate other t hours CAUSE (Disease or injury that initiated events reaulting in death) LAST cirrhosis 6 alcohol death o unknown the atten Mental H any Injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY requires that the MEDICAL signed by the 1 TES 2 NO OF DEATH? shows a 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Item 2 certificate h HOSPITAL 1 YES 2 NO OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) the 0 28e. DATE OF INJURY (Month, Day, Year) 27, MANNER OF DEATH 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY with t marked, 1. Natural Pending Investigation 1 YES 2 NO BY After 1 ATTENDING 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 3 Suicide COMPLETED 6 Could not be DIRECTOR: hours after tem 28 Is 4 Homicide 8 29a. CERTIFIER 1 2 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. (Check only one) FUNERAL within 72 h = MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(e) and menner se stated. TO THE HOSPITA
TO THE FUNERA
Be filed within 7
IMPORTANT: 1 29b. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE PO 823 Resident .15.95 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) anzadeh Good EB 1 7 1995 31. DATE FILED (Month, Day, Year) 15 .95

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

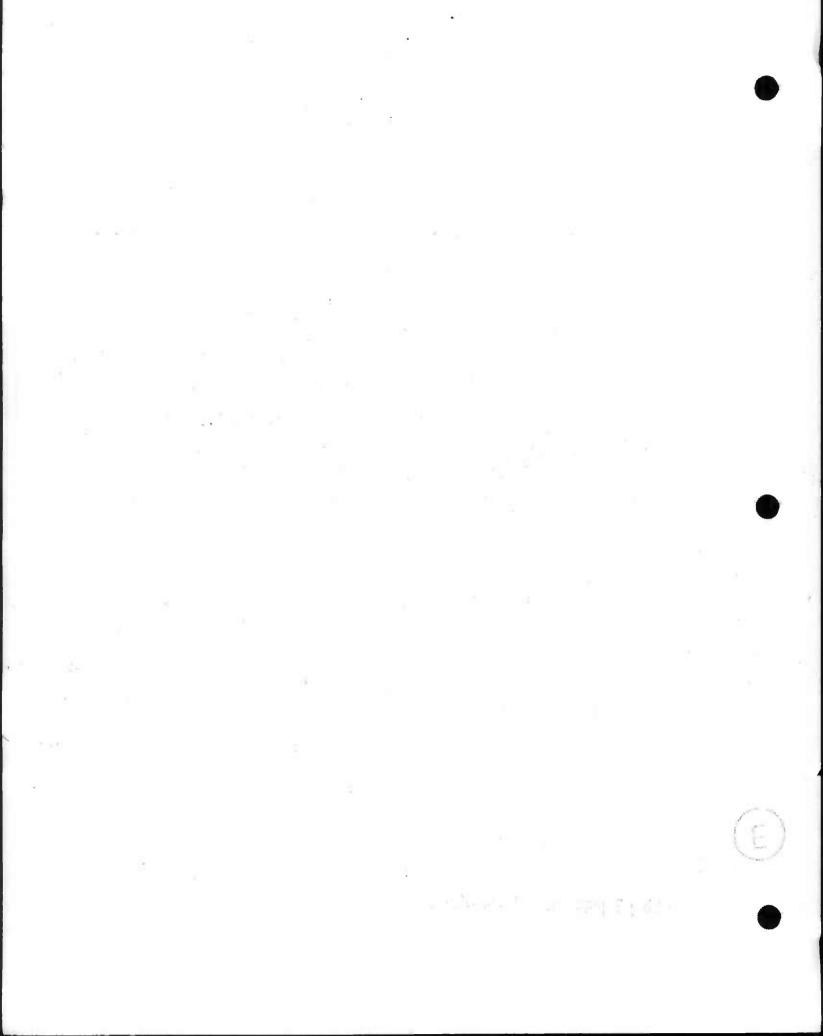
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

	REGISTRAR		CERTIFIC	CATE OF	DEATH	RE	G. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	Dani	d Dieberd	T 2 - 4 -		2. DATE OF DE			3. TIME OF DEATN		
	DAVID LIS	ron- Davi	d Richard	Liston		МОНТН	15	95	0900	Дм	
			(In yrs. last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	T. DATE OF BI	1.0		LACE (State or Foreig		
	153-58-9605	1X M 2 □ F 36		ONTHS DAYS	HOURS MIN.	oct.05,	1958	Penn	LAGE (State or Foreig	gn	
	9e. FACILITY NAME (If not institution, give street	of end number)		b. CITY, TOWN	OR LOCATION OF D			INTY OF DEA			
DIRECTOR	CALVERT MEMORIA	L HOSPITA	L _	PRINC	CE FRED	ERICK	C	CALVE	RT		
입	10e. STATE 10b. COUNTY	-	10c, CITY	TOWN OR LOCAT	ION				and business over		
DIR	Maryland Baltimo			Baltimo:	re			10d. INSIDE CITY LIMITS? 1 YES 2 NO	,		
FUNERAL	100. STREET AND NUMBER 1819 Rambling Ridge	02	2 1209				USA	IAT COUNTRY?			
3				13, WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (See			- American Indian,	$\overline{}$	
B	1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER I FORCES? 1 2 YES IF YES GIVE WAR OR O	2 NO	2 NO If yes, specify Cuben, Mexicar IES 1 YES 2 ANO Specify.			etc.)	Black,	White etc. White		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co.		16a. DECEDENT'S US (Give kind of work	UAL OCCUPATION	ON	16b, KIND	OF BUSINESS/IN	DUSTRY			
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use r	etired.)							
MP		3 yrs.	Construct	ion In	spector	Nati	ional Gu	ard			
8	17. FATNER'S NAME (First, Middle, Last)	T			18. MOTHER'S NA						
BE	Joseph James	Liston				Pauline	dlove				
2	190. INFORMANT'S NAME (Type/Print) Kathy Lee Erlandsor	. Tigton	19b. MAILING AL	DRESS (Street e	nd Number or Rural	Route Number, Cit	or Town, State, Zi	p Code)	01000		
	200, METNOD OF DISPOSITION				Ridge I						
	1 Buriel 20 Cremetion 3 Remove	If from State	PLACE AND DATE OF	tory, 1	nc. 02/1	16/95	20c. LOCATION — Baltimo	re, M	D		
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SETTAN THE		22 NAME AN	APPRESS OF FA	ciety of	f Marvla	and I	nc		
	George E. MacNa	.bb		299 E	rederic	c Rd. Ba	altimore	. MD	21 228	- 1	
	23. PART I. Enter the diseeses, or con	npilcetions that cause	d the desth. Do not	enter the mo	de of dying, suc	h ss cardiec o	r respiratory ar	rest,	Approximate		
	shock, or heart feilure. I.is IMMEDIATE CAUSE (Final	R only one cause on a	ech ilne.						Onset and D		
		MULTIPLE	IN TUR	38							
DUE TO (OR AS A CONSEQUENCE OF):										\neg	
Z	Sequentially list conditions,										
CERTIFICATION	if any, leading to immediata cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):								
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Ē	that initiated events resulting in deeth) LAST		outdebounde of).						İ	- 1	
	d								+	=	
EDICAL	PART II. Other significent conditions	ontributing to deeth b	out not resulting in t	the underlying	ceuse given in	Part I. 24a. 1	MAS AN AUTOPSY PERFORMED?		VERE AUTOPSY FINDII	NGS	
8							YES 2 NO	C	COMPLETION OF CAUS	BE	
ME						_ (`	•		NYES 2 NO	- 1	
	DID TOBACCO USE CONTRIE	BUTE TO CAUSE O	F DEATH YES	\square NO \square	UNCERTAIL	V 🗆 📗			7	_ 1	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:	26. PLACE OF DEATH								
YS!		☐ Inpetient 2 TX ER/Outp		THER: Nursing Home	5 🗆 Reeldence	8 Other (Spec	lfy)				
표	27. MANNER OF DEATN	28e. DATE OF INJURY (Mgnth, Dev. Year)	O 8 2 1	F 28c. INJI	URY AT	28d. DESCRIBE	NOW INJURY OC	CURED		\neg	
BY	1 Netural 5 Pending 2 Accident Investigation	2-115/95	0827	M 1 🗆 Y	Acres 1	PEDISTI	MAN STR	UCK B	Y VARAICE	E	
	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, atc. (Spec	- At home, ferm, stre-	et, factory, office		28f. LOCATION City or Town	(Street and Number	or Rural Rou	ite Number		
Ë I	4 Homicide determined		STREET				OWIE SHO	PROI	PT4 PRINC	BUNE	
2 1	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIA	N: To the best of my know	ledge, death occurred a	t the time, date	end place, end due	to the cause(e) e	and manner ee sta	ted.	41		
COMPLETED	one) 2 MEDICAL EXAMINER: (n end/or Investigation, I						/VV and menner ee stated	2	
ů l	296. SIGNATURE AND TITLE OF CENTIFIED	00	1		29c. LICENSE NUM				fonth, Day, Year)	\dashv	
m	White Us	WAH!	1		O.C.N		▶ F		16,1995		
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Pri	nt)	2.0.1				-0,1)	-	
	MARIO F. GONEJ	R MD	111 Penr		et, Bal	Ltimor	e, Mar	yland	1 21201		
	FEB 1 7 1995	JULY OF WHILE	charlet								

BALTIMORE, MARYLAND 21215-0020	YSICIAN: The law requires that the death certificate be executed within 4. frours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should thit is State Debt, of Health and Mental Hydlere prior to buriat, cremation, or removal.	s medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	E. IOSFIAL OR ITTENDING PHYSICIAN: The law requires that the death certificate be executed within a	HE FULL OF EXTOR: After this certificate has been signed by the attending physician and completely filled in by the fur-	ORTANT, if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE OF				3. TIME OF DEATH
	Herman						February 11 1995 3.45				3.45 PM			
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER		IF UNDER		7. DATE OF	BIRTH		8. BIRTH	IPLACE (State or Foreign
	020-10-774		1 M 2 D F	87	YRS.	MONTHS	DAYS	HOURS	MIN.	Oct 7	19	07	New	"York
_	90. FACILITY NAME (If not in	stitution, give s	reet end number)			9b. CITY	, TOWN	OR LOCATE	ON OF DE	EATH		9c. COL	INTY OF D	EATH
OR	Suburban H	Hospi	tal			В	eth	esda				Mor	tog	omery
ב	RESIDENCE OF DEC	10b. COUNTY			40. 017			WWW.						
IR.						Y, TOWN								10d. INSIDE CITY LIMITS?
	Maryland 100. STREET AND NUMBER	Mont	gomery			Sili	-	Spr.						1 XYES 2 NO
RA	15100 Inte	rlag	hon Dr	7nt	0 0 7		100							WHAT COUNTRY?
N N	11. MARITAL STATUS	er Lac		IT EVER IN U.S. AR					U.S.A.					
BY FUNERAL DIRECTOR	1 Never Married 2 🖔		FORCES? 1	XYES 2 1	10		If yes, sp	ecify Cubin	n, Mexice	n, Puerto Rice	licen, stc.) Black, White, stc.			
	3 Widowed 4 Divo	rced		WW II			1 169	ZAL NU	Specify	γ: -			Speci	ite
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 18b. KIND OF BUSINESS/INDUSTRY						100								
COMPLETED	Elementary/Secondary (0		College (1-4 or 5		. Do NOT u	se retired.)		or or working	W					
₽ I			5+		Τe	each	er					ucat	ion	
8	17. FATHER'S NAME (First, Mi									ME (First, Mide				
8	Abraham		tman							ha E				
2	19a. INFORMANT'S NAME (7)									Route Number,				3 00054
	Nancy Wan:													d 20854
	12 Buriel 2 ☐ Cremetio 4 ☐ Donation 5 ☐ Other	n 3 🗌 Rem	cual from State	20b. PLACE	matory or o	ther plece)	SITION (NE	ime of	- L	2713	20c. LO	CATION -	City or To	wn, State aryland
	21. SIGNATURE OF FUNERAL	- relation	ENGER	- Toude	an P	lemo	NAMEA	ID ADDRES	L'GE	ut 190	15	Olne	y Ma	aryland
		MA	110/	1 1						n Fun	era]	l Ho	mes	
		COL P	MILO	ula	u	100	110	Chi	urch	. Wi	rair	nia	22	2046
	23. PART i. Enter the di ahock, or he	eart feliure.	complications the List only one cau	it caused tha de ise on aach lina	ath. Do i	not entar	the mo	da of dyl	ng, suci	h se cerdisc	or reapi	iratory ar	rest,	Approximats interval Between
	HAMEDIATE CAUSE (Fin		٨		0	0								Onset and Daath
	resulting in deeth)	→	a. Acu	OR AS A CONSE	al	+ 11	lur	_						
_		_				,								
ō	Sequentially list conditi- if any, leeding to immed	DUENCE O	F):											
SAT	cause. Enter UNDERLY	NG	Con	onary	a	rter	H	cl	15e	ace				
CERTIFICATION	CAUSE (Disease or Injustified initiated events			(OR AS A CONSE										
E	resulting in death) LAS1		d											
	PART II. Other significa	nt condition	s contributing to	death but not r	equiting	In the us	darluin	2 001100 0	diam'r	Don't I a	. 1400 000		T.,,	
MEDICAL.	110.700.0				ouditing	in the di	out ly in	y cause y	giveti iii	Pait 1, 24	PERFOR		240.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
							_			_ 1	YES 2	D-NO		OF DEATH?
_	DID TOBACCO U	SE CONTI	DIRLITE TO CA	LICE OF DEA	TLI VI	:c 🗆 :	VO F	LINIC	ERTAIN	1/5				1 ☐ YES 2/□ NO
AN I	25. WAS CASE REFERRED TO		NIBOTE TO CA		E OF DEAT) DIAC	EKIAII	N D				
Sic	EXAMINER?	1800	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER			aldense	8 Other (S				
PHYSICIAN:	27. MANNER OF DEATH		28e. DATE OF	INJURY	28b. TIM	E OF	28c. INJ	URY AT		28d. DESCR		NJURY OC	CURED	
ВУР		Pending nvestigation	(Month, D	MA	INJ	M		RK? (ES 2 _	NO [
	3 Suicide 6 0	Could not be	28e. PLACE O	F INJURY — At ho	me, ferm, s	street, fect	ory, offic	•		281. LOCATIO	N (Street a	ind Numbe	r or Rural R	loute Number,
1	4 Homicide	letermined		No. (Option)	14					City or k	own, State)			
PLE	29e. CERTIFIER (Check only	FYING PHYSI	CIAN: To the best of	my knowledge, de	oth occum	ed at the t	lme, date	end place,	end due	to the cause(e) end mar	mer es sta	ted.	
COMPLETED	one) 2 MEDI	CAL EXAMINE	R: On the beele of e	xamination end/or i	nveatigatio	n, in my o	pinion, d	eath occur	ed at the	time, date and	l place, en	d due to ti	ne ceuse(e) end menner ee stated.
ы С	29b. SIGNATURE AND TITLE							29c. LICE						(Month, Day, Year)
00	Suran	2	m	mo					395					1-95
임	30. NAME AND ADDRESS OF			SE OF DEATH (ITEM	1 27) (Type,	Print)								1 1 1
		radle		e. cl	revu	, a	rase	,	mi,	20	815			
	31. DATE FILED (Month, Day,)		32 REGISTRA	R'S SIGNATURE				-						
	FEB 1 7 199	15 X	ind arenase	rnandall										
	HI HI	7												DHMH-18 Rev 1/89



FOR

1 -

STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

212-09-9460

1. DECEDENT'S NAME (First, Middle, Last)

Albert

Meyers

6. AGE (In yrs. last birthday)

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1 🕅 M 2 🗌 F March 7, permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Old Court Nursing Center DIRECTOR Randallstown RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Md. Baltimore Reisterstown FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 409 Chartley Park Rd. 21136 use as the burial-transit retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 A YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR PATES BY 3 Widowed 4 Divorced COMPLETED 18a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION (Specify only highest grade complete Elementary/Secondary (0-12) be detached for College (1-4 or 5+) Salesman once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Isaac Meyers Gertrude F funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Fmances Meyers 409 Chartley Park Rd., Reisterstown, Md. 21136 ins after death. Page 6 may be pe 200. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Burial 2 Cremation 3 Removal from State Baltimore National Cem. Feb.19 1995 Baltimore, Md. 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY
Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. completely filled in by the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel prior to burial, cremation, ä LOX YERW event. resulting in death) DUE TO YOR AS A CO executed traumatic tours CERTIFICATION E Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING DUE TO OR AS A CONSEQUENCE OF physician 2 certificate CAUSE (Disease or Injury other Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events Bulguage resulting in death) LAST injury, or Health and Mental P. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part J. MEDICAL Ħ shows any certificate has be the State Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one Hell certificate HOSPITAL: U
1 □ Impetient 2 □ ER/Outpetient 3 □ DOA I THE S THE ng Home 5 🗆 Residence 6 🗀 Other (Specify) marked, or 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Weer) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED SH. Netural ä 5 Pending 1 YES 2 NO BY Affect death Accident 28e. PLACE OF INJURY -- At home, farm, street, factory, office hullding, alm. (Execute) 3 Sutcide 45 28f. LOCATION (Street and Number or Rural Route Number City or Team, State) 6 Could not be COMPLETED DIRECTOR affer 23 4 - Homicide HOUTE Item 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. FUNERAL WITHIN 72 N TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 _ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER THE F BE 29c. LICENSE NUMBER 2 CAUSE OF DEATH (TEM 27) (Type, Print) andallstown MD21133 310 dld Kd 0 W8/

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

DAYS

IF UNDER 24 HRS.

HOURS

YEAR

9c. COUNTY OF DEATH

Baltimore

10g. CITIZEN OF WHAT COUNTRY?

U.S.A.

Specify:

Collections

244. WAS AN AUTOPSY

20c. LOCATION — City or Town, Stata

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign

Maryland

14. RACE — American Indian, Black, White, etc.

10d. INSIDE CITY

1 YES 2 KNO

White

21117

Approximete

34b. WERE AUTOPSY FRIDINGS

AVAILABLE PRIOR TO

COMPLETION OF CAUSE T THE E NO

interval Between

7:45 P.M

2. DATE OF DEATH

7. DATE OF BIRTH (Month, Day, Yea

Feb. 16,1995

DHMH-16 Rev 1/89

Day, Year)

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Item17 2-17-95 FilmG720 W.H.Per F/H Item4 2-21-95 FilmG720 W.H.Per F/H 1 - STATE

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

L DECERDITS MAME (First, Modific, Late) Emmett Dent Specific Michael Spec
A SOCAL SECURITY MANAGE OF A SOCIAL SECURITY MANAGEM MASSON MA
4. SOLAN SECURITY MANNERS 1. SEX 1.
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See FECLITY NAME (if not statistice, per state and number) See COUNTY OF DEATH Annapolis See COUNTY OF DEATH Annapolis Annapolis Annapolis Annapolis Ide. COUNTY Annapolis Ide. COUNTY Ide.
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MD Anne Arundel Annapolis Street and Number 2554 N. Haven Cove 21401 Santa
106. STREET AND NUMBER 2554 N. Haven Cove 21401 107. PCODE 21401 108. CITIZED SO WHAT COUNTRY? USA 11. MARITAL STATUS 12. MARITAL STATUS 13. WORNERS PROFISED TO FIRSPANIC ORIGIN? (Specify Yes or No
25.54 N. HAVEN COVE TI. MARITAL STATUS TI. M
11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorce PROCEST 1 YES 2 MO FYCES 2 MO If YES 2 MO If YES 2 MO IF YES 0/MOVED A CONSEQUENCE OF): 12. WAS DECEDENT SEDUCATION If Yes specify Cuban, Mestican, Purifo Ricen, etc.) 1 Yes 2 (Modewed 4 Divorce Ricen, etc.) 1 Yes 2 (Modewed Ricen, etc.) 1
Concess 1 Yes 2 Yes 2 Yes
St. DECEDENT'S EDUCATION 15a. DECEDENT'S USUAL OCCUPATION 15b. KIND OF BUSINESS/INDUSTRY 15
Specify only highest grade completed) Sementary (0-12) College (1-4 or 5+) Owner Printing
Elementary/Secondary (0-12) 8 Owner Printing 15. FATHER'S NAME (First, Middle, Last) Unknown 16. MOTHER'S NAME (First, Middle, Maidlen Surneme) Unknown 16. MOTHER'S NAME (First, Middle, Last) Unknown 17. FATHER'S NAME (First, Middle, Last) Unknown 18. MOTHER'S NAME (First, Middle, Maidlen Surneme) Unknown 18. MOTHER'S NAME (First, Middle, Maidlen Surneme) Unknown 18. MOTHER'S NAME (First, Middle, Maidlen Surneme) Unknown 18. MOTHER'S NAME (First, Middle, Maidlen Surneme) Unknown 18. MOTHER'S NAME (First, Middle, Maidlen Surneme) Unknown 18. MOTHER'S NAME (First, Middle, Maidlen Surneme) Unknown 18. MOTHER'S NAME (First, Middle, Maidlen Surneme) Unknown 18. MOTHER'S NAME (First, Middle, Maidlen Surneme) Unknown 18. MOTHER'S NAME (First, Middle, Maidlen Surneme) Unknown 18. MOTHER'S NAME (First, Middle, Maidlen Surneme) Unknown 18. MOTHER'S NAME (First, Middle, Maidlen Surneme) Unknown 18. MOTHER'S NAME (First, Middle, Maidlen Surneme) Unknown 18. MOTHER'S NAME (First, Middle, Maidlen Surneme) Unknown 18. MOTHER'S NAME (First, Middle, Maidlen Surneme) Unknown 19. MALING ADDRESS (Street and Number or Rural Route Number. City or Town, Stete, Zerole) 20. LOCATION – City or Town, Stete, Zerole) 20. LOCATION – City or Town, Stete, Zerole) 20. LOCATION – City or Town, Stete, Zerole) 20. LOCATION – City or Town, Stete, Zerole) 20. LOCATION – City or Town, Stete, Zerole) 20. LOCATION – City or Town, Stete, Zerole) 20. LOCATION – City or Town, Stete, Zerole) 20. LOCATION – City or Town, Stete, Zerole) 20. LOCATION – City or Town, Stete, Zerole) 20. LOCATION – City or Town, Stete, Zerole) 21. Value To Coal A Location – City or Town, Stete, Zerole) 21. Location – City or Town, Stete, Zerole) 22. Location – City or Town, Stete, Zerole) 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory street, MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re
117. FATHER'S NAME (First, Middle, Last) Unknown 199. INFORMANT'S NAME (First, Middle, Maidlen Surneme) Unknown 199. INFORMA
Unknown 190. INFORMANT'S NAME (Type/Print) 190. INFORMANT'S NAME (Type/Print) 200. METHOD OF DISPOSITION 1 Rundle 2 Cremention 3 Removal from State 4 Donation 6 Other (Seeder) 20. PLACE AND DATE OF DISPOSITION (Name of community) or other place) 4 Donation 6 Other (Seeder) 21. BIOMATURE OF TIDERAY Share List only one ceuse on each line. 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, interval desease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):
19e. INFORMANT'S NAME (Type/Print) Elsie Lillian Milstead 2554 N. Haven Cove, Annapolis, MD 21401 20e. METHOD OF DISPOSITION 1
Elsie Lillian Milstead 2554 N. Haven Cove, Annapolis, MD 21401 20s. METHOD OF DISPOSITION 1
20s. METHOD OF DISPOSITION 1 Street 2 Cremetton 3 Removal from State 2 Cremeton, crematory or other place) 4 Date 20c. Location — City or Town, State 2 Cremeton, crematory or other place) 4 Date 20c. Location — City or Town, State 2 Cremeton, crematory or other place) 4 Date 20c. Location — City or Town, State 2 Cremeton, crematory or other place) 4 Date 20c. Location — City or Town, State 2 Cremeton, crematory or other place) 4 Date 20c. Location — City or Town, State 2 Cremeton, crematory or other place) 4 Date 20c. Location — City or Town, State 2 Cremeton, crematory or other place) 4 Date 20c. Location — City or Town, State 2 Cremeton, crematory or other place) 4 Date 20c. Location — City or Town, State 2 Cremeton, crematory or other place) 4 Date 2 Cremeton, crematory or other place) 4 Date 2 Cremeton, crematory or other place) 4 Date 2 Cremeton, crematory or other place) 4 Date 2 Cremeton, crematory or other place) 4 Date 2 Cremeton, cremeton, state 4 Date 2 Cremeton, state 4 Date 2 Cremeton, state 4 Date 2 Cremeton, state 4 Date 2 Cremeton, state 4 Date 2 Cremeton, state 4 Date 2 Cremeton, state 4 Date 2 Cremeton, state 4 Date 2 Cremeton, state 4 Date 2 Cremeton, state 4 Date 2 Cremeton, state 4 Date 2 Cremeton, state 4 Date 2 Cremeton, state 4 Date 2 Cremeton, state 4 Date 2 Cremeto
Sequentially list conditions, if smy, leeding in death) Due to (or as a consequence or): Sequentially list conditions, if smy, leeding in death) LAST
2. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory streat, interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):
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MINISION OF VITAL RECORDS, P.O. BOX 68760

THE DE AFFENDING PHYSICIAN: The law requires that the death certificate be executed with the construction of the certained by the integral. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should a hours after death with the State Dept. of Health and Menial Hygiene prior to burial, cremation, or removal.	
TO THE COURT OF TENDIN TO THE FLY THE DIRECTOR. Aft De flied within 72 hours after dea	

			95	05001
E STRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.		
NT'S NAME (First, Middle, Last)	La de La La La La La La La La La La La La La	2. DATE OF DEATH MONTH DAY	YEAR	3. TIME OF DEAT

	FOR 1 - STATE REGISTRAR	TE STATE OF MARTLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE							
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH 3. TIME OF DEATH				
18	JULIA MI					2 /9		1258 P M	
OR	4. SOCIAL SECURITY NUMBER 220-24-3517	1 M 2 XF 8	(In yrs. lest birthday) 5 YRS.	IF UNDER 1 YES		7. DATE OF BIRTH (Month, Day, Year) 11-20-09	Count	HPLACE (State or Foreign (Y)) ryland	
	9e. FACILITY NAME (If not Institution, give street and number) Church Hospital Baltimore City - 9c. COUNTY OF DEATH -							DEATH	
2	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY								
COMPLETED BY FUNERAL DIRECTOR	Maryland -			Baltimore				10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
	740 S. Decker Avenue				21224	U.S.A.			
	11. MARITAL STATUS 1 Never Married 2 Married 3.XXVidowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 XNO	I1 yes	DECENDENT OF HISPAI apecify Cuben, Mexica (ES 2 XNO Specif	in, Puerto Rican, atc.) Black		E — American Indian, k, White, atc.	
	(Specify only highest grade completed) (Give Elementery/Secondary (0-12) College (1-4 or 5+)			ECENT'S USUAL OCCUPATION Island of work done during most of working to NOT use refined.) US ewife			OF BUSINESS/INDUSTRY		
	17. FATHER'S NAME (First, Middle, Last)		<u> </u>		16. MOTHER'S NA	ME (First, Middle, Malden	Surname)		
ш	Charles R. Saddler					gusta Flerry			
TO B	19a. INFORMANT'S NAME (Type/Print)		ILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
-	Mrs. Joan Hoffman 740 S. Decker Avenue, Baltimore, Md. 21224								
	20a. METHOD OF DISPOSITION 1-1 Burlal 2 Cremetion 3 Rem	coval from State 20	b. PLACE AND DATE (of DISPOSITION	(Name of		CATION — City or To		
	1-12 Burlai 2 Cremetion 3 Removal from State Cemetery crematory or other place) 2-17 Baltimore, Md.						Md.		
1	Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224								
- 1	23. PART I. Enter the diseases, or o			302	L Eastern	Ave., Balt	timore. M		
CERTIFICATION	ahock, or heart failura. IMMEDIATE CAUSE (Finsi disease or condition resulting in death)	a. Bilitya	each line.	ynn	AA	in as caldrac or respi	ratory arreat,	Approximata Interval Between Onset and Desth // 16/95	
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLVING CAUSE (Disease or injury that initiated eventa resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
AL C	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FINDINGS								
S	4 Gregorius George Facilities Prior To COMPLETION OF CA							AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDIC	@ Remarks of Stateman Type 1 YES 2 MO OF DEATHY								
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO								
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:								
1YS	1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)								
BY PH	1 Natural 5 Pending (Month, Day, Year) NUURY WORK? 2 Accident Investigation M 1 YES 2 NO								
	3 Suicide 4 Homicide 8 Could not be detarmined 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28a. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)								
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINEFI: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.								
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER Solution MD 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year)								
	BAYANI B. ELMA M.O. 3023 EASTERN AVE BALTO MD 21224								
31. DATE FILED (MONTH, Day, Year) 32. REGISTRAR'S SIGNATURE 2/14/9 SFEB 1. 71995 Jalia Window Replace									
	/							OHM	

